A New Front Door for Homeless Services

Coordinated Intake and Homeless System Entry Planning

In Sonoma County, California

Sonoma County Community Development Commission

on behalf of the **Sonoma County Continuum of Care**

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Summary

On May 20, 2009, President Obama signed into law the Homeless Emergency And Rapid Transition to Housing (HEARTH) Act (2009), which included a requirement that all local homeless Continua of Care (CoCs) establish and operate a centralized or coordinated entry point into the local system of care. In this paper we refer to this as Coordinated Intake (CI).

This paper has been developed to update the community about the development of a Coordinated Intake system, and the progress of Sonoma County's implementation. It will aid ongoing meaningful discussions about the further development and implementation of a coordinated intake system.

The federally mandated deadline for implementation of Coordinated Intake is by the end of 2014. Sonoma County has targeted the fall of 2014 to launch Phase I of the system with a system operator to be identified, and two initial target populations: homeless families with children, and homeless individuals referred through a County-funded Homeless Outreach Team.

The federally-mandated January 2013 Homeless Count found 4,280 people in Sonoma County who met the narrowest federal definition of homelessness – sleeping in a place not meant for human habitation or in an emergency shelter or transitional housing facility. Count data indicates more than 300 people become homeless every month, and current data analysis indicates an average of 280 new names being added to the Homeless Management Information System (HMIS) each month for the past year. There is a high volume of need and many people never touch homeless services.

Following direction by the U.S. Department of Housing and Urban Development (HUD), our coordinated intake system has been designed to streamline program intake, assessment and service referral using comprehensive and standardized processes throughout the defined geographic area of Sonoma County. It shall be easily accessed by individuals and families seeking homeless-dedicated assistance.

The Sonoma County Coordinated Intake process is anticipated to positively address federally mandated HEARTH Performance Measures as well as locally identified challenges to service provision. The primary goal of the CI project will be to reduce the time people are homeless, and ultimately contribute to a reduction in the number of people experiencing homelessness.

Local planning for this mandate began in 2011 through the Coordinated Intake Workgroup of the Sonoma County CoC. Discussions during local planning sessions have focused on identification of accessible points of system entry for homeless clients, adoption of standardized assessment tools, definition of target subpopulations and collaborative alignment among homeless services providers.

Activities being developed to support an effective CI system include the selection of a qualified program operator, transparent communication with key stakeholders, strengthening collaborative partner relationships, garnering community support and development of critical technology and workflow systems.

In Sonoma County, there are 7.7 homeless persons per 1,000 residents, a rate of homelessness that is nearly four times the national rate, and well above other California communities that use similar methodology. With funding losses over the past few years and a renewed public focus on homelessness in our community, efficient use of our county's homeless service resources has never been more critical. As the CI project aims to promote system efficiency supportive of a reduction in Sonoma County homelessness, evaluation of the CI system will be ongoing and modifications made as necessary.

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The Case for Homeless System Coordination

From 2009 to 2013, progressive point-in-time homeless counts indicate that the number of chronically homeless individuals[1] in Sonoma County has increased from 979 (2009) to 1,148 (2013), representing 27% of Sonoma County's total homeless population. This is significantly above the national average of 16% of the homeless population.

One of the most worrisome trends emerging from the 2013 Homeless Count was that one-third of the local homeless population is under the age of 25. Of 277 teens under the age of 18, 98% had no place to stay on the night of the count. A second finding of great concern was that 2 out of 3 homeless persons had a serious medical condition.

The length of time people were homeless had increased since the previous count: more than half of the adult participants in the 2013 Count survey had been homeless for more than a year, and over 80% of them had been homeless more than 3 months. Also based on this data, we estimate that over 300 people become homeless in Sonoma County every month. No system-wide coordination exists to help them resolve their housing crisis.

Sonoma County experiences a serious shortage of affordable housing stock. People staying in emergency shelter and transitional housing programs face great difficulties accessing the affordable housing market. At any point in time we are able to shelter only 23% of the homeless population. Yet the 2013 emergency shelter bed utilization recorded for the Annual Report of Homelessness (AHAR) was only 86% for the period October 1, 2012-September 30, 2013. Various factors contribute to less than optimal utilization, but lack of streamlining the intake process is a key factor.

Not only does HUD require coordination of entry (e.g., Coordinated Intake) into homeless services, but local providers have expressed frustration at the perceived lack of service resources, and concern with their inability to help clients exit homelessness quickly. The county's two largest emergency shelter providers state that clients can remain on a waiting list anywhere from six weeks to several months (for single adults), and up to six months (for families with children). Many

[1] The federal definition of Chronic Homelessness is: an unaccompanied homeless person with a disabling condition, who has been continuously homeless for a year or more, or who has had four (4) episodes of homelessness in the last three (3) years.

emergency shelter providers are mandated through funding agreements to serve people on a "first-come, first-served" basis, which requires significant staff resources to maintain bed waiting lists, which require homeless people to call in on a daily basis to preserve their place in line. Thus, inadvertently, our system currently prioritizes those best able to navigate the waiting list process rather than those with high needs based on medical vulnerabilities.

The research we conducted in the process of designing a Coordinated Intake system for Sonoma County highlighted serious challenges to accessing services, lengthy periods of homelessness without accessing services at all, inappropriate referrals, and difficulties achieving high utilization due to a lack of easily accessible information and multiple barriers. All these illustrate the urgent need for homeless system coordination.

CI Development

Not unlike many providers across the nation, homeless services developed in a disparate way across Sonoma County's 1500+ square-mile expanse. Despite great cooperation in developing practice and sharing their models with each other over 15 years through the Sonoma County Continuum of Care, each shelter created its own screening criteria, waiting list, and intake processes. As a result, consumers of homeless services were required to complete similar processes many times over, often trying to access the wrong services.

In September 2011 a subcommittee of the CoC known as the Coordinated Intake Workgroup began planning activities for coordinated intake with the mission of designing:

> *… a coordinated system for triaging homeless persons upon entry to the Continuum of Care—one that results in their efficiently receiving the individualized services/resources that would reduce the length of time they are homeless. Design will include policy & practice recommendations deemed necessary to support effective implementation of such a system.*

While HUD now prioritizes persons with vulnerable health for entry to homeless services, over those who were more able to navigate a "first-come, first-served" system, the directive to establish coordinated intake enables local communities to set priorities around the use of their resources. A quote from HUD's *Snaps Weekly Focus* of July 18, 2013 states:

> *We believe that the implementation of coordinated assessment will improve the delivery of housing and services in the long run, and we want communities to plan for it carefully. The implementation plan must make sense for the CoC, homeless services providers, relevant mainstream service providers, and the individuals and families that need our programs. It is imperative that a comprehensive group of stakeholders take part in the systems design, and that ample time and space are given to stakeholder feedback and performance review during the early stages of implementation.*

When local planning began in 2011, resources describing the experience of other CoC's in the development of a coordinated intake system were very scant. The National Alliance to End Homelessness' Center for Capacity Building took an early lead in publishing sample planning documents and assessments, and in the past year more materials have become available as early-adopting communities began to publish their models and development guides.

Coordinated Intake's Key Stakeholders

The following regulatory, government, non-profit and other communities entities will have an impact on the achievement of system goals, or will be affected by the system outcomes:

U.S. Department of Housing and Urban Development (HUD) - The HEARTH Act has set a bold direction nationally to create systems and programs to rapidly move homeless individuals and families from homelessness into housing, and a system of care for achieving the most sustainable housing outcomes. Ongoing evidence that the CI project is operational will help to sustain the CoC competitive funding that comes to Sonoma County in the amount of $2.7 million per year.

California Department of Housing and Community Development (HCD) – The Interim Rule for the Emergency Solutions Grant program (ESG—formerly Emergency Shelter Grants) requires that all ESG-funded programs in a community with a Coordinated Intake system must participate in that system. For the first time in 2013, HCD's Notice of Funding Availability for Balance of State ESG funding included this language:

> *Once the CoC has developed a Centralized Assessment System or a Coordinated Assessment System in accordance with requirements to be established by HUD, each ESG-funded Program or Project within the CoCs area must use that assessment system. The Applicant must work with the CoC to ensure the screening, assessment and referral of Program Participants are consistent with the Written Standards. A Victim Service Provider may choose not to use the CoC Centralized or Coordinated Assessment System.*

Sonoma County Board of Supervisors –Through its Upstream Investments and Health Action initiatives, the County of Sonoma has endorsed identifying successful, data-informed practices that can help to improve health and social welfare in Sonoma County, including reducing the rate of homelessness. On August 19th, 2014 the Board accepted the 2014 Update to the 10-Year Homeless Action Plan, a key component of which relies on Coordinated Intake as such a data-informed best practice that can streamline access to homeless services, quicken the pace of housing placement, and ultimately contribute to reducing homelessness.

Sonoma County's Homeless Population – A "client-centered" approach is a primary focal point of HUD's requirement for system coordination. This approach will reduce the length of time people are homeless, and will reduce the chance for relapse into homelessness, by enabling the client to participate in the decision about what type of housing and service delivery will work for them.

Sonoma County Continuum of Care (CoC) – Our County-wide planning body coordinates homeless-dedicated housing and services funding by working collaboratively with service providers to assure the best use of local resources.

Non-CoC Homeless Service Providers – Faith-based organizations, churches, homeless advocacy groups, food programs and other organizations that provide supplemental services to homeless persons will receive clear communication regarding how to access housing for the people they serve.

Local Funders – Public funders and private foundations that fund homeless service efforts will be able to use information from the CI system, to ensure their efforts are effective in reducing homelessness.

Local Systems of Care – Sonoma County departments such as Department of Health Services and Human Services Department, as well as non-government entities such as community health clinics and hospitals, will benefit from closer communication and more appropriate referrals into their systems of care.

Our Community – The CI system will play an important role in addressing the impact of homelessness on neighborhoods, business operators, educational systems and other entities that experience the negative social impact of homelessness.

The Coordinated Intake Workgroup

An original team of interested CoC members began meeting in September of 2011 to draft steps for the system. They envisioned central access via phone or in person, beginning with a call to 2-1-1, or with a walk-in to any homeless day services center in Sonoma County. The system would provide a "warm" referral, handing clients off to the most well-matched service provider either by a direct telephone transfer (including to police or other crisis line if appropriate), directly introducing them to the right staff person, or making an appointment for them in person.

The group aimed to administer a comprehensive *screening* (only) that would answer all critical questions to determine the best short-term housing placement. The screening would flag key issues that required more in-depth assessment; the group planned to assign deeper assessment to local subject matter experts. Over time, the group developed a prototype common screening tool (see Attachment 10) and conducted a beta-test using a paper format in the summer and fall of 2012.

During the fall of 2012, an opportunity emerged to fund operations of the CI system through reallocation of federal CoC funding. The Sonoma County Community Development Commission (SCCDC) applied for a grant of $102,198 (to be matched with $40,000 in local funds for a total of $142,198 in, annual operating funds) with the intent of requesting proposals from potential operators once the funds were in contract. The SCCDC entered into contract for these funds in July 2014.

The CI Workgroup took a break during the fall and winter of 2012, reconvening in February 2013 to update members on what had happened since the summer. The SCCDC's HMIS Coordinator recommended an exploratory process to ensure that the most suitable technology tool would accommodate not only federal requirements, but expand and enhance service delivery to provider agencies as well.

CI Workgroup membership had changed during the hiatus; while earlier decisions made by the group were documented, new factors such as funding availability and technology options necessitated the deeper group discovery process. The CoC Coordinator compiled a table of decisions made earlier in the planning process, to inform further decisions and to mitigate against the practice of revisiting former decisions as the composition of the group changed over time. The attached Decision Log (Attachment 7) uses an organizational tool suggested by various Coordinated Intake Planning Guides to accomplish this, which facilitated the CI Workgroup focusing on answering questions for which no decision had yet been recorded.

The CI design process included gathering broad-based input on challenges experienced by

both agencies and consumers who deal with program intake and referral to other services. Representatives of participating agencies were interviewed about their current processes and discussed options for system improvement. Common themes were gathered into a set of local system change goals summarized in the Program Performance Measures section on p. 22 (Local System Needs to be Addressed).

Additional research was conducted by the workgroup members in the form of site visits and participation in peer group discussions with other CoC communities. The HMIS Coordinator attended an "Advanced Approach" to Coordinated Assessment training presented by Matt White of Abt Associates at the April 2013 National Human Services Data Conference in Seattle, WA. The HMIS Coordinator has also been participating in two monthly discussions (one between HUD representatives and HMIS vendors, and the other a group of HMIS administrators) and has been able to hear about coordinated intake planning being conducted nationwide.

A key survey of homeless consumers was incorporated as part of the discovery process. Between September 26 and November 8, 2013, four providers conducted eight (8) one-to-one interviews and four (4) consumer focus groups. Participants included a total of 43 adults ages 19-64, with the average age being 48.5. Of them, 20 respondents were male, and 23 were female. Seven (7) were unsheltered; 19 were living in emergency shelters; 1 lived in transitional housing; 1 was at risk of losing housing; and 15 were stably housed. The make-up of the respondent group, and their responses, were impacted by locations where they were conducted (for example, very few responses were available from unsheltered persons because most focus groups were held in sheltered settings). The survey results are included as Attachment 5.

The CoC Coordinator, along with seven CI workgroup participants participated in a site visit to Connecting Point in San Francisco on October 4, 2013. Those in attendance reported back to the larger CI workgroup and a comprehensive review of their visit is included on Attachment 6.

Since 2013, content about other communities' coordinated intake systems has become more available on the Internet, providing more ideas for incorporation into our process. Materials from the National Alliance to End Homelessness (NAEH); OrgCode Consulting; King County, WA; Sacramento CA; and other sources have become available and are being used to inform local planning.

The recent release of HUD's Final 2014 HMIS Data Manual and a technology update to our HMIS vendor's software have together afforded an enhanced HMIS technology that will more adequately accommodate the overall CI system design as we move forward.

Program Design

To meet the federal expectation for the launch of a local Coordinated Intake system, an initial roll-out date of October 2014 is planned. The initial launch is targeted to address homeless families as an initial phase and, except as noted below, is anticipated to operate for a period of no longer than six (6) months, before expanding to other populations, for the purpose of evaluation and adjustments to program design. Coordinated Intake will also become operational for individual homeless clients located through the newly established Sonoma County Homeless Outreach Team (HOT) as soon as the HOT team is operational in late 2014. Once the CI system is adequately tested and adjusted as thoroughly as possible, it will be opened to all other homeless subpopulations (anticipated Spring 2015).

Beta testing and feedback sessions will be conducted in three primary areas beginning October 2014 and are anticipated to include: review of the Efforts to Outcomes (EtO) HMIS Coordinated Intake program setup using EtO's TouchPoints functionality; scheduling of participants for in-depth case management appointments; and testing the suitability of program matching to provider services.

Once operating at full capacity, the CI Project is anticipated to place 2,500 persons into a range of housing solutions annually. Approximately 80% of these will have physical disabilities, developmental disabilities, chronic health problems, HIV/AIDS, mental health challenges, or histories of substance abuse. A summarized project plan with milestones and dates is provided in Attachment 2.

Overall System Flow

Using a hybrid de-centralized model, clients will either contact a 24-hour central phone system operated by 2-1-1 in collaboration with the CI Program Operator, or be able to walk in to one of several geographical locations to complete a pre-screening process. 2-1-1 or Coordinated Intake program staff will conduct the pre-screening using the VI-SPDAT (a.k.a. Vulnerability Index-Service Prioritization Decision Assistance Tool) screening tool. The VI-SPDAT is an evidenced-based screening tool developed to combine the strength of two widely used assessments: the full SPDAT, and the Vulnerability Index developed by the 100,000 Homes Campaign. Copies of VI-SPDAT screening tools are attached as Attachment 9.

The initial intake and pre-screening process will include the completion of a homeless client Release of Information (ROI), completion of the VI-SPDAT (for families or individuals as appropriate), and referrals to short-term emergency services with a focus on quick exits from homelessness. After completion of the pre-screening process, clients will be scheduled for a more comprehensive evidence-based assessment using the (full) SPDAT assessment by the CI program staff. These appointments will be conducted at one of several walk-in centers located throughout

the county. After completion of the SPDAT, clients will be placed on one of several wait lists delineated by provider type. While on a waiting list, they will receive Crisis Case Management including service referrals to, for example, where and how to obtain needed personal identification, initial steps to establish income, and information about housing program eligibility and participation requirements.

CI Program case management staff will manage the overall program wait lists and check for new openings on a daily basis. Homeless participants will be notified of bed or unit openings when the most suitable match becomes available. A client's position on a the wait list will be determined by a combination of three factors:

- Full SPDAT assessment score
- Case Manager/Participant observation and interaction
- Bed availability based on program type

Providers are expected to accept client referrals forwarded by the CI staff, and will have the ability to view the VI-SPDAT and SPDAT assessments along with case notes taken by the Coordinated Intake staff. Clients who are not accepted into the referred housing programs due to provider concerns or poor program fit will then be scheduled for a case conferencing session. Case conference models are currently being researched and details on the adopted model will be released at a later date.

Participants will be enrolled and case managed through Coordinate Intake Program until they either:

1) Are referred and accepted into a Sonoma County housing program;
2) Formally notify CI program staff that they no longer wish to be considered for a referral and request to be dismissed from the program; or
3) Do not engage with services, and CI program staff is unable to locate or contact them for more than 90 days.

Management of "housed" program Wait List(s)

Wait Lists for each HMIS Participating Agency will be combined by program type and managed electronically by the CI Program staff broken down by the following categories:

Housing Type	Population
Emergency Shelter	Individuals vs. Families
Rapid Re-Housing	Individuals vs. Families
Permanent Supportive Housing	Individuals vs. Families
Transitional Housing	Individuals vs. Families
Special Housed Programs (mental health focus, youth under 18 etc.)	Individuals, Families, Youth etc.

Homeless participants assigned to waiting lists will be prioritized based on their vulnerability factors and length of homelessness as revealed by the SPDAT scoring tools. Participants assessing at "less need" for intervention will be case managed to seek other housing options during the period they remain on waiting lists.

Specialized shelters or housing programs that operate exclusively on coordinated referrals offered to clients of Sonoma County Behavioral Health, and other exclusive referrals, will continue their existing process unless or until the CI process can provide a satisfactory substitute process.

System Requirements

The Sonoma County Coordinated Intake Model will meet all key HUD requirements and will make every effort to address HUD's conceptual framework. These include:

	Key Concept	How Addressed
	Comprehensive and Standardized Assessment Tools	Adoption of evidence-based pre-screening and assessment tools; training on their use
	Assessment of Client Needs	Facilitated through incorporation of a weighted, evidence-based set of tools that appropriately targets clients early in the process
	Easy Client Access	Wide-coverage public relations; agency websites content; assertive field outreach, use of traditional and social media
	Geographic Coverage	Intake centers geographically dispersed; staff trained
	No Wrong Door Approach	Participants have access by telephone or through any walk-in setting; clear guidelines for system entry
	Special Populations, Domestic Violence, Veterans and Youth	Number of subpopulations addressed as the CI system grows and can accurately track various subpopulations
	Trained Staff	Initial training program; ongoing training and evaluation

Evidence-Based Screening and Assessment

An evidence-based assessment (EBA) emphasizes the use of research and theory to inform the selection of targets, the methods and measures used in the assessment, and the process itself. EBAs have been independently peer-reviewed, and the results of the reviews are published.

Although the CI Workgroup actively engaged in designing its own comprehensive client assessment, once EBAs became easily available the workgroup elected to move forward with the highly recommended VI-SPDAT and full SPDAT for screening and assessment tools.[2] In July 2014 HUD published the CPD-14-012 Notice, which stated: "CoC's must utilize a standardized assessment tool, in accordance with 24 CFT 578.3, or process."

The selected tools will include the VI-SPDAT for caller pre-screening, which will identify length of homelessness and medical vulnerability, and a more comprehensive assessment called the SPDAT, which will be used to direct the most appropriate program referral and can be used as a basis for ongoing case management.

The SPDAT tools have been extensively tested and reviewed, and are being employed by over 100 CoC's throughout the United States. The SPDAT tools are recognized and recommended for use as an emerging practice by the National Alliance to End Homelessness and the National 100,000 Homes Campaign.

Highlights of the full SPDAT assessment tool include:

- The SPDAT provides baseline information that can be used to set reasonable indicators for years to come;
- The findings are reliable baseline data needed for Social Return on Investment Forecast and Analysis;
- The SPDAT appropriately guides frontline workers and team leaders for an intensive case management approach to service delivery;
- The SPDAT prioritizes which clients should receive which services and reliably tracks the needs and service response to clients over time.

In April 2014, the VI- SPDAT screening tool was field tested in the local 100,000 Homes Registry Week. The VI-SPDAT is now incorporated into the EtO HMIS; the full SPDAT assessment will be incorporated into the EtO HMIS software by the HMIS Coordinator by October 1, 2014.

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[2]SPDAT stands for Service Prioritization Decision Assistance Tool; VI-SPDAT indicates this tool's combination with the Vulnerability Index Survey.

Database Technology

The Homeless Management Information System, or HMIS, is an online tracking system that all CoC's are mandated to utilize for aggregate data collection. The system stores and maintains individual client data with HIPAA[3]-level compliance, and produces reports on the performance of federally funded homeless programs. In 2012, the Sonoma County HMIS converted from an earlier HMIS system to Social Solutions Efforts to Outcomes' (EtO) HMIS. The EtO HMIS takes data tracking beyond basic statistical data collection into a more robust case management and performance measurement environment.

While the conversion proved to be problematic, the use of the system has stabilized and offers a far more useful functionality set than our prior HMIS. An EtO Site and Coordinated Intake Program have been built, and custom reports are being designed to aid the CI Program Operator with participant intake, referrals and bed assignments.

The Sonoma County HMIS user base has now worked with EtO HMIS for over two years. Several agencies are branching out beyond the minimally-required HMIS functionality to utilize advanced feature sets such as case noting, client referrals, group attendance and HUD-compliant personnel time tracking. Sonoma County's HMIS Coordinator is highly experienced in database system design and there are several "power users" at agencies located within the local HMIS community.

A newer core function (included with our existing EtO system) is called TouchPoints. Social Solutions is developing its 2nd generation HMIS tracking using TouchPoints functionality. While the TouchPoints module is newer to the EtO product lineup, in 2014 the HMIS Coordinator has designed assessment and reporting systems using this function and finds reporting design to be more functional than the earlier database technology used to generate custom reporting.

Early on, thought had been given to the development of a stand-alone, external data tracking system for CI. While the design of data points and subsequent reporting would be minimal, the cost of integration of a separate system to our existing HMIS and programming for HIPAA compliance would not be cost-effective.

Given the fact that as of 2014 the HMIS which tracks 99% of the county's emergency shelter beds has been determined capable of housing the required CI functionality, the current HMIS

[3] HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The law protects the confidentiality and security of healthcare information.

is a logical choice for the primary CI technology tool. The HMIS not only serves as a data repository to produce HUD and local reporting, but it supports the design architecture that will allow us to create an evaluation framework for the CI Program.

HMIS Configuration and Workflows

As mentioned above, client pre-screening, case management and program referrals will be accomplished using the Sonoma County HMIS Efforts to Outcomes. A dedicated Coordinated Intake Virtual Site has been established and is being configured to host the two SPDAT assessments, client wait lists configured by housing program type, internal referrals from the CI program to other programs in the EtO Enterprise, and case noting.

The Coordinated Intake Program will operate within the EtO HMIS utilizing these general processes:

2-1-1 – Initial Contact and Screening

A basic 2-1-1 intake will incorporate questions that will lead staff to determine HUD homeless status. 2-1-1 will capture initial data in their proprietary system. If the participant Head of Household (HOH) indicates he/she is in danger, an immediate referral will be made to the appropriate agency(s) including 9-1-1, Psychiatric Emergency Services, the Domestic Violence Hotline, and others.

Once the participant Head of Household establishes homeless status and has consented to the terms of the approved Release of Information form, 2-1-1 staff will perform all other intake tasks in the EtO HMIS as follows:

Login into EtO

1. Perform “Search/Enroll Enterprise Participant” OR “Add New Household” (if the participant is not current in the HMIS)
2. Update Participant Demographics data points (Head of Household only)
3. Administer the VI-SPDAT screening for Families or Individuals as appropriate
4. Schedule the first Case Management appt with Coordinated Intake staff (using Create Appointment function)
5. Review the CI “No Show” policy with the Participant

Coordinated Intake Program Operator - Deeper Assessment and Ongoing Case Management

Daily

1. Daily check and/or update the Appointment Schedule (EtO - View Appointments).
2. Daily check the Enterprise Open Bed List Report and follow up with provider point of contact with questions (EtO custom open bed report).
3. Daily print/review the current outstanding Wait Lists for each project type (EtO Group

List by Project Type).

4. Daily confirm participant(s) will appear for case management sessions.
5. Meet with Head of Household (HOH) Participant(s) to conduct initial deep assessment utilizing the SPDAT for Families or Individuals as appropriate. Determine final SPDAT score and discuss Wait List placement results with Participant.
6. Add Participant to appropriate Wait List (EtO Group Management).
7. Complete targeted Wait List TouchPoint (EtO Wait List TouchPoint).
8. Assess HOH for basic service referrals, document and provide to Participant (using EtO - Add a Referral function).
9. Continually match bed openings to participants based on Wait List attributes.

Monthly (or as needed)

1. Update Coordinated Intake dedicated website.
2. Update Referral information kept in the Coordinated Intake Virtual Site.

Capacity Building

Training and capacity building for components of the CI program will be structured and ongoing. Training tools will include written documentation, video training, peer group discussion and ongoing program evaluation. Audiences will include 2-1-1 staff and volunteers, CI Operator staff and interns, and staff of walk-in centers, among others. Training topics will include, but not be limited to:

- Client Security and Ethics – informed by the federal HMIS Initiative & HIPAA
- Administration of the Sonoma County Continuum of Care Consent for the Release Of Confidential Information
- Intake and Assessment interviewing methodologies using the VI-SDAT and SPDAT tools
- EtO data entry steps for intake, TouchPoint Assessments, Appointment Scheduling, Wait List Management, Referral Confirmation and Program Referrals
- Wait List and Crisis Case Management strategies using Motivational Interviewing Techniques
- Maintaining HMIS timeliness and data quality requirements
- HMIS reporting and performance analysis

Coordinated Intake Program Operator

A Request for Qualifications (RFQ) is anticipated to be released in September 2014 for the purpose of selecting an operator for the CI project. The operator will need to possess capabilities such as experience with the provision of services to homeless persons, operating an intake system, experience providing crisis case management, and the ability to continually assess and improve

program delivery through the identification of emerging practices in HUD-compliant coordinated intake. It is anticipated the primary responsibilities of the Coordinated Intake Provider will include:

- Oversight of the combined housing program wait lists including keeping information current
- Supervision and training of program staff and/or volunteers to meet the program goals
- Real-time data entry and data quality maintenance of the CI Program in the HMIS
- Staying apprised of best practices for coordinated intake systems nationwide and incorporation of those practices as indicated
- Participate in a quarterly evaluation process to identify suggestions for improvement and revisions to program design as appropriate
- Work with the Sonoma County Continuum of Care to meet performance goals

Risk Analysis

While broad local consensus has emerged on many crucial design points through the CI workgroup, there are outstanding operational issues that will need to be addressed when the program starts and on an ongoing basis.

First, some Sonoma County shelters and transitional housing facilities are required to use a first come, first served approach for waiting lists because of funding requirements, especially with State of California funding agreements. Many of these funding agreements will expire in 2015, and admission priorities for individual facilities can then be changed in consultation with the funding organizations. Establishing a separate Coordinated Intake program that manages all waiting lists prior to contact with shelters will help those operators to comply with the separate federal priority on housing the longest-term, most vulnerable homeless persons.

Second, discussions need to take place about what happens to homeless clients who are not accepted into program services due to past or current behavior, or when the referred to agency determines the client is otherwise not appropriate. Other communities have instituted a case conference contingency for such situations, and local providers have indicated their interest in exploring this as an option. Planning the elements of a case conferencing system will not be addressed by the program launch date. As a component of Coordinated Intake, as the primary funding agency, HUD requires a written policy outlining the acceptable reasons for participant rejection/denial from service. This discussion has begun in common system-wide program standards development groups mandated through the HEARTH Act, but a single policy needs to be developed for the county's CoC.

Third, while many program eligibility standards are shared by many Sonoma County providers,

consensus is still needed to resolve differences in these agency-level requirements that would otherwise render CI referrals ineffective. These discussions have been seeded through CoC-wide program standards development, with draft policies completed for our local Rapid Re-Housing and Homeless Prevention & Diversion programs. Meetings are currently taking place to develop common standards for Emergency Shelters, Permanent Supportive Housing, and Transitional Housing.

Fourth, an ongoing evaluation mechanism and baseline measurements still need to be vetted by the CI Workgroup. Performance measures mandated by our CoC funding agreement are listed on page 20, but local indicators of program effectiveness are also needed, such as client feedback loops, number of days on wait lists, appropriateness of referrals etc.

Lastly, we are cognizant that in order to appropriately refer and serve individuals and families who are at-risk of homelessness or considered homeless under federal definitions other HUD's, additional funding will be required. This is because current HUD funding limits use of those funds to only services benefiting those that are literally homeless using the narrow HUD definition of homelessness. System-wide prevention program standards and national best practices will be incorporated into any future prevention component of the Coordinated Intake project.

Public Relations and Engagement

Coordinated Intake will be publicized using a variety of methods so that the information is broadly disseminated throughout the county. The 2-1-1 and SCCDC will work with the selected Coordinated Intake Provider to establish a public relations campaign to get the word out. 2-1-1 will edit their public web to link to a dedicated Coordinated Intake web URL managed by the CI provider. The initial web page will display information about who qualifies for accessing services through the CI program, steps to contact the 2-1-1, and information to have on hand for the initial screening.

In collaboration with SCCDC, the Coordinated Intake provider will be responsible for an outreach effort to all Sonoma County homeless services providers. This effort will make use of several community wiki's, HMIS training and SCCDC technical assistance sessions. The SCCDC plans to host a series of service partner/key stakeholder information updates toward the end of 2014 and beyond.

Social communication will include use of Facebook Page, Twitter account and Linked In accounts using the title "Sonoma Homeless" and hash tag searches #SonomaHomeless. An appropriate social media campaign will be developed in compliance with the County of Sonoma's Social Media policy and be maintained by the provider.

Program Performance Measures

Coordinated Intake will change the ways that homeless consumers access and receive services and the ways that programs operate. Lack of substantial data on the experience of homeless consumers can be seen as both as positive and negative. In one sense, the lack of baseline data from other CoCs leaves us guessing about what constitutes a well-working program. On the other hand, our door is wide open to work from a basic set of expectations and develop and assess progress towards our local challenges as the program develops. The overall expectation is that our CI system will better match homeless people to the most appropriate services in a timely manner. It is also anticipated to make better use of our local resources, relieving case managers of the intake and assessment role, and allowing them to deliver more beneficial case management services to move participants toward permanent housing placements.

Evaluation of the CI Project will include the following documentation and performance measures. Federal performance measures required by the HEARTH Act are noted where relevant.

	Program Outcome	Measurement
1.	Number of screenings conducted, and success of outreach to homeless individuals and families (HEARTH Performance Measure)	In the startup year we anticipate at least 300 screenings broken down as follows: Homeless Families – 75-100 households; Homeless Outreach Team – 229 screenings. In subsequent years we anticipate conducting screenings for approximately 3,366 persons to be placed on waiting lists and receive referrals. Of these we anticipate 74%, or 2,500 will be placed in housing (both permanent and temporary) over a five year timeframe.
2.	Client Satisfaction	80% of program participants surveyed will indicate their satisfaction with the coordinated intake system, through consumer surveys taken at program exit or, if this is unworkable, on housing entry.
3.	Persons with unmet needs related to physical disability, developmental disability, chronic health, HIV/AIDS, mental health, or substance abuse.	At least 40% of those presenting with each of these issues will be referred and connected to services.
4.	Reduce the length of time individuals and families are homeless (a HEARTH Performance Measure)	• In the start-up year, establish a baseline number of days from CI system entry (initial screening) to permanent housing placement. In following years, decrease the number of days by 5% annually. • We will measure the % of persons entering the CI program, who exit directly to a permanent housing situation. • We will measure the % of persons exiting CI, who enter permanent housing after stays in shelters or transitional housing. The goal for family shelters is to exit 40% of participants to permanent housing; single adult shelters and all transitional housing have the goal of increasing exits to permanent housing by 1% annually. For 2015, the system wide goals for exits to permanent housing are: 25% of persons exiting single adult shelters; 54% of persons exiting singles transitional housing; and 71% of persons exiting family transitional housing. • We will also measure the % of shelter exits to homeless situations on the assumption that better targeting of services will result in a reduction in exits to homeless status from the current rate of 60%.

In addition, we will collect a number of program management measures to assist with fine-tuning program delivery, such as: days from initial screening to full assessment; number of referrals; number of accepted referrals; days on waiting lists prior to housing placement; number of referrals back to a case conference (due to non-acceptance).

The chart below identifies issues uncovered during the CI Workgroup discovery sessions. Potential solutions have been suggested that we will work toward to quantify successes over the next few years.

Local System Needs Identified in the Planning Process

	Sonoma County Providers	Issue Identified	Potential Solutions:
1.	Gaps in emergency housing capacity	Lack of options for "true" emergency shelter/Lack of "wet" or behavior-based shelter services for persons with substance abuse or other issues/Client age at both ends of spectrum youth - elder addressed/Improve effectiveness of outreach/Continual need for new strategies to access permanent housing in increasingly tight rental market.	The 10-Year Homeless Action Plan 2014 Update suggests the primary issue is the shortage of affordable permanent housing, which creates a bottleneck in shelters. Shelters are experimenting with behavior-based methods to accommodate needs. CI will aim to better target for expertise with specific subpopulations through Wait Lists targeted to the various housing types—and as permanent housing programs are phased in, to refer directly into those units as possible.
2.	Lack of current information about types and availability of services	Providers struggle with knowing the most current information about local homeless services which in turn wastes valuable time to continually contact a provider for current updates.	The CI Program Operator will become the central point for maintaining current information about service availability and at least until housing placement be the primary point of communication for the Participant for service referral.
3.	Client challenges to accessing services	Clients lack wherewithal to apply/interview for housing without housing locator assistance/needs to be accompanied by case manager or housing locator to facilitate service linkage	Wait List Case Management interns will dedicate time to homeless clients to connect them to services. A component of the case management will include participant education about housing programs and service placement. The "Housing Locator" role will be performed in partnership with local Rapid Re-Housing programs rather than as a component of the CI.
4.	Wait List Management	Clients retained on wait lists for appropriate program entry expend a great deal of staff effort to contact other providers for housing placement. Policies for "no show" clients vary across the CoC and it is difficult both for participants to continually check in with multiple providers and time consuming for agency staff to field these calls.	It is anticipated that the use of evidence-based SPDAT tools will provide an appropriately targeted housing placement. This will be evaluated over the course of the first year. It will be the role of the CI Provider to be aware of all homeless program eligibility criteria and maintain that information in the form of EtO Entity Attributes.
5.	Compromised Health services & resources	Health compromised homeless clients face more barriers to enter shelter & housing/Identify sources for fragile/health compromised clients and seeking respite beds/Lack of medical care or being linked to a medical home	The use of the SPDAT tools and targeted Wait List placement, along with referrals provided by CI case managers, is anticipated to address this.

	Sonoma County Providers	Issue Identified	Potential Solutions:
6.	Client unable to receive services for behavioral issues	Issues including use of alcohol & drugs, including prescription marijuana use/ refusal to give up pets/behavior/legal conflicts of interest county-wide	These issues will be ongoing and potential solutions are anticipated to be identified through the work of the Program Standards Groups.
7.	Client Communication	Logistical difficulty communicating with client; lack of resources to help homeless client stay in the loop, childcare support, voicemail, mail pickup (there is no way to check in)	CI Case Managers will work to assure and document the best way to locate the participant for service referral or housing placement. The number of participants who disappear will be monitored for improvement over time.

Future planning efforts through the program evaluation system will include plans to monitor both HEARTH Performance Goals and challenges identified by providers, to assure progress is being made.

Funding and Resource Support

The FY2012 Continuum of Care Notice of Funding Availability offered a one-time opportunity to reallocate funds from Supportive Services Only (SSO) projects to create a new Coordinated or Centralized Intake system. Once all provisions of the NOFA were taken into account, the amount available for Coordinated Intake was $102,198. This amount required a cash match and the County agreed to over-match by contributing $40,000 annually, for a total budget of $142,198. That contract was finalized in July 2014.

A subcommittee met in December 2012 to develop a staffing plan and program design using this budget. This subcommittee included staff from several agencies that had been involved in the planning effort over the previous year. The resulting budget included a 1.0 Program Coordinator ($50,000 base plus 30% taxes and benefits); stipends for 3 interns (at $2,500/year), hardware and software for 6 sites (at $2,500 per site), and a 1.0 FTE Lead Crisis Case Manager (at $40,000 base plus 30% taxes and benefits).

Hardware and software funds would be used in subsequent years to expand the paid intern staff. It was anticipated that the Program Coordinator's key role would be to develop, expand and maintain the provider partnership and ensure ongoing training on the screening tools. This effort would be supported by the intern staff, or funds would be directed to homeless services agencies as a subcontract to ensure these agencies had the capacity to participate. The Lead Crisis Case Manager would provide crisis case management to persons on waiting lists to maximize the possibility of rapid departures from homelessness. A similar function had been provided to the Family Support Center on a part-time basis for one year, and was a factor in a significant reduction in the number of homeless families between 2011 and 2013.

The Coordinated Intake Project was submitted by the Sonoma County Community Development Commission in the FY2012 CoC application, with the intent of subcontracting the project once a contract with HUD was in place.

Cost Components Table

The Cost Components Table below incorporates new cost items identified through the CI planning process, and reconciles them with the funds currently available:

Startup Costs	Program Coordinator	1.0 FTE @ $50,000 annual + benefits	$65,000
	Interns (2)	Stipends @ $2,500 each	$5,000
	Lead Crisis Case Manager	1.0 FTE @ $40,000 annual + benefits	$52,000
	Technology	Computer/tablet purchases & 2-1-1 referral	$9,815
	HMIS Cash Match		$1,200
	Communications Planning & Training	Web development	$2,500
	Administrative expense	to be split between SCCDC & program operator	$6,685
	Total Anticipated Y1		**$142,200**
Ongoing Costs	Program Coordinator	1.0 FTE @ $50,000 annual + benefits	$65,000
	Interns (3)	Stipends @ $2,500 each	$7,500
	Lead Crisis Case Manager	1.0 FTE @ $40,000 annual + benefits	$52,000
	Technology	Computer/tablet purchases & 2-1-1 referral	$5,015
	HMIS Cash Match		$2,000
	Evaluation		$4,000
	Administrative expense	to be split between SCCDC & program operator	$6,685
	Total Anticipated Annual		**$142,200**

Looking Ahead

In the next few months, the Coordinated Intake workgroup will formulate final steps of the CI plan knowing that continuous improvement and the expectations for program iteration will continue. We have attempted to address all issues uncovered throughout our planning process, but we know that more will surface as we begin program operation.

A beta test period will begin October 1st, and our experience with a small subpopulation will be evaluated to inform Phase I and subsequent implementations. The early rollout of Coordinated Intake will target homeless families with at least one adult and one child, and unsheltered homeless adults served by a new County-funded Homeless Outreach Team.

A substantial public relations effort targeted to county departments, law enforcement, health care providers and community-at-large will be incorporated into the larger program rollout while the beta-test period is operational.

As a CoC composed of dedicated homeless service providers, we look forward to the reporting of both quantifiable and anecdotal evidence that we are making a positive impact on homelessness throughout Sonoma County.

The Sonoma County Community Development Commission welcomes comment regarding the Coordinated Intake Planning done on behalf of the Sonoma County Continuum of Care. Please feel free to contact either:

Jenny Helbraun Abramson
Sonoma County Continuum of Care Coordinator
(707) 565-7548
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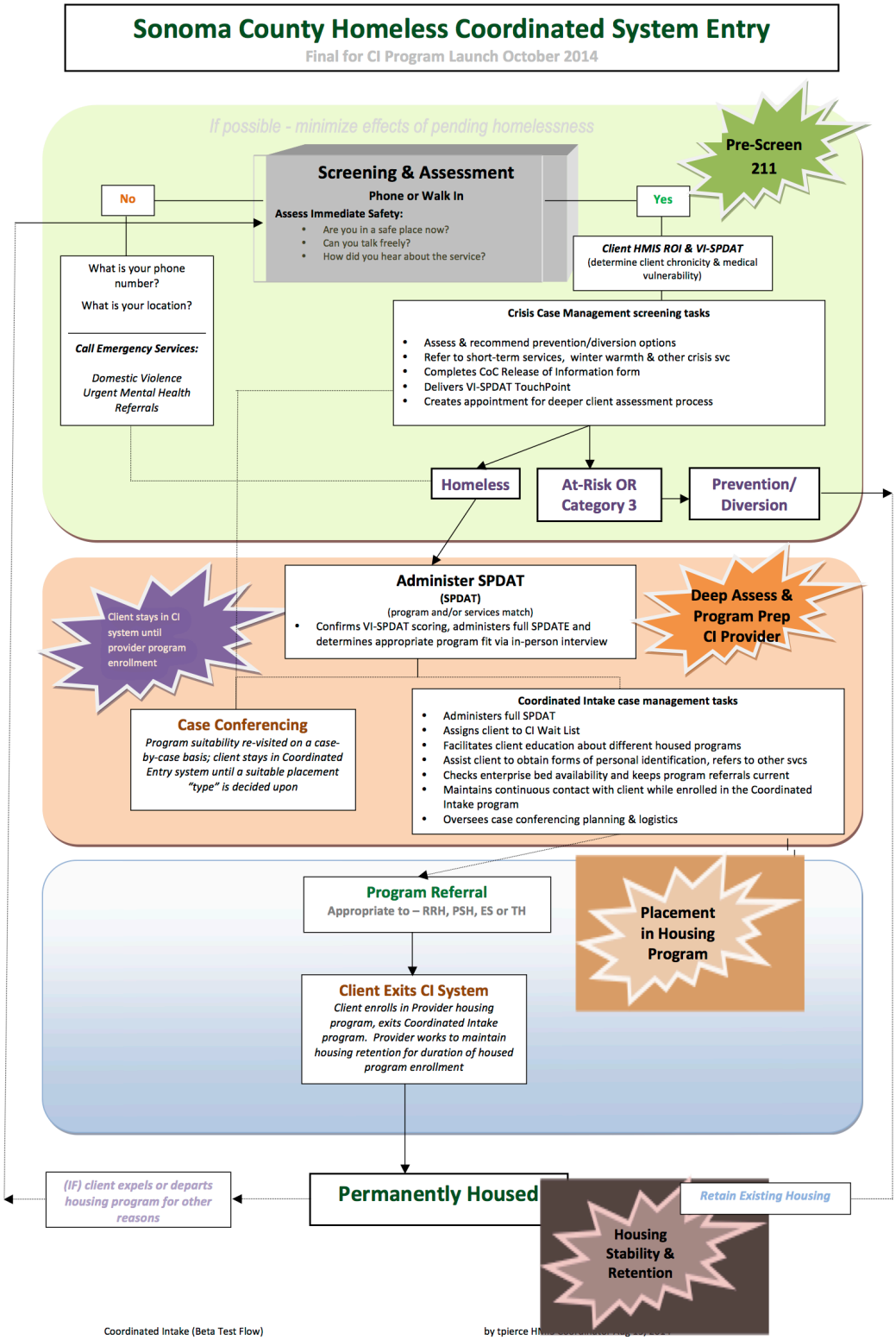
Schedule of Attachments

ATTACHMENT 1 – Coordinated Intake System Flow Chart

A summary workflow chart developed in consultation with the Coordinated Intake Workgroup illustrating the overall client flow of the Coordinated Intake System.


Sonoma County Homeless Coordinated System Entry
Final for CI Program Launch October 2014
If possible - minimize effects of pending homelessness
Pre-Screen 211
Screening & Assessment
Phone or Walk In
Assess Immediate Safety:
Are you in a safe place now?
Can you talk freely?
How did you hear about the service?
No
Yes
What is your phone number?
What is your location?
Call Emergency Services:
Domestic Violence
Urgent Mental Health
Referrals
Client HMIS ROI & VI-SPDAT
(determine client chronicity & medical vulnerability)
Crisis Case Management screening tasks
Assess & recommend prevention/diversion options
Refer to short-term services, winter warmth & other crisis svc
Completes CoC Release of Information form
Delivers VI-SPDAT TouchPoint
Creates appointment for deeper client assessment process
Homeless
At-Risk OR Category 3
Prevention/ Diversion
Client stays in CI system until provider program enrollment
Administer SPDAT
(SPDAT)
(program and/or services match)
Confirms VI-SPDAT scoring, administers full SPDATE and determines appropriate program fit via in-person interview
Deep Assess & Program Prep CI Provider
Case Conferencing
Program suitability re-visited on a case-by-case basis; client stays in Coordinated Entry system until a suitable placement "type" is decided upon
Coordinated Intake case management tasks
Administers full SPDAT
Assigns client to CI Wait List
Facilitates client education about different housed programs
Assist client to obtain forms of personal identification, refers to other svcs
Checks enterprise bed availability and keeps program referrals current
Maintains continuous contact with client while enrolled in the Coordinated Intake program
Oversees case conferencing planning & logistics
Program Referral
Appropriate to – RRH, PSH, ES or TH
Placement in Housing Program
Client Exits CI System
Client enrolls in Provider housing program, exits Coordinated Intake program. Provider works to maintain housing retention for duration of housed program enrollment
(IF) client expels or departs housing program for other reasons
Permanently Housed
Retain Existing Housing
Housing Stability & Retention
Coordinated Intake (Beta Test Flow)
by tpierce

ATTACHMENT 2 – Summary Project Plan

A summary list of anticipated first year targeted accomplishments.

September to December 2014

- Selection of CI Program Operator
- Onboard Operator with Coordinated Intake Workgroup and homeless service providers with targeted family programs
- Train Operator and 211 staff on use of SPDAT tools
- Test EtO Program functionality
- Entry of initial SPDAT, Case Management and Referral Data into the HMIS
- Make referrals to family program providers
- Screening and assessment of first Sonoma County Homeless Outreach Team (HOT) referrals
- Evaluate program progress focusing on appropriateness of referrals

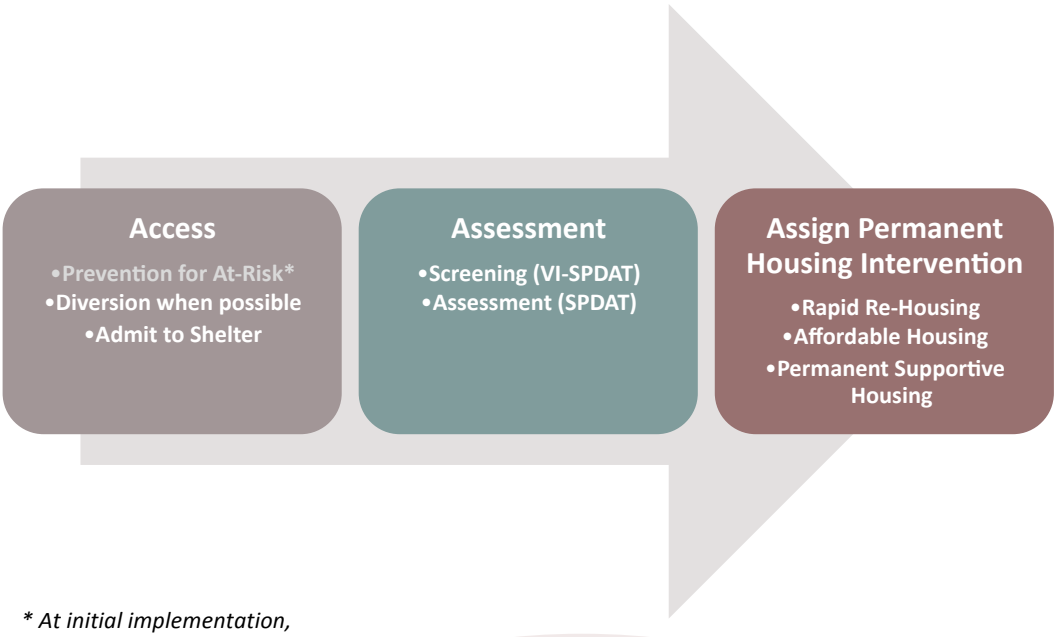
January to March 2015

- Ongoing screening, assessment and referral of homeless families and HOT clients
- Rollout full public relations campaign
- Survey participating providers about program effectiveness
- Evaluate program progress with continued focus on referrals and key indicators

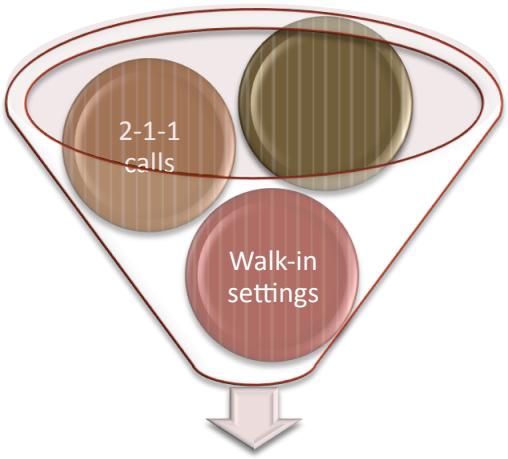
April to June 2015

- Full incorporation of the Sonoma County HOT Team work
- Open program to homeless individuals
- Rollout full public relations campaign
- Survey participating providers
- Evaluate program progress with a focus on HOT Team integration

ATTACHMENT 3 – USICH Rapid Response Framework & CI Full Service Diagram



** At initial implementation, available funds can only serve literally homeless persons. We envision the addition of Prevention Assistance for At-Risk persons, and of Benefits Advocacy to establish income, to be delivered in conjunction with Coordinated Intake.*



Coordinated Intake

Intake
- Screening (VI-SPDAT)
- Assessment (SPDAT)

Referral
- Assignment of Housing Solution
- Education & Crisis Case Management

Case Managment
- Case Conference for problematic referrals
- Initial Steps to Establish Income (e.g. benefits advocacy)*

ATTACHMENT 4 – Key Coordinated Intake Service Referrals

A list of key service providers and partner referrals has been identified by the CI Workgroup and will be created in the HMIS for participant service referrals once a homeless participant enters the CI program. Additional services and resource supports will be added as they become known.

211 I&R
Affordable Housing Builders
Athena House
Becoming Independent
Burbank Housing
Casa Celmeca
CCOC Day Service
Churches & Faith Based Organizations
Cities & Town Councils
Cold Calls (Unidentified)
Craig's List Private Homeowners
Criminal Justice Task Force
Drug Abuse Alternatives Center
DSLC
Emergency Responders-fire, police ambulance
Homeless Action !
Jails, Incarceration and Correctional Facilities
Jewish Family Services
North Bay Organizing
North Bay Regional
Our Verity
Rosenburg Building
Safe Parking Programs
School Boards
School Districts
Schools
Section 8 Housing Programs
SLE's in both cities
SoCo Behavioral Health (Housing Specialist & FACT Team)
SoCo Court Referred Probation
SoCo Property Managers
SOS Day Service
Task Force on the Homeless
The Living Room
VASH List at the City
Vet Connect
Veteran's Administration (VA)
YWCA Safe House

ATTACHMENT 5 – Homeless Consumer Input Survey

Consumer Input Survey Results

Between September 26 and November 8, 2013, providers conducted eight (8) one-to-one interviews and four (4) consumer focus groups. Participants included a total of 43 adults ages 19-64, with the average age being 48.5. Of them, 20 respondents were Male, and 23 were Female. Seven (7) were unsheltered; 19 were living in emergency shelters; 1 in transitional housing; 1 was at risk of losing housing; and 15 were stably housed. The make-up of the respondent group, and their responses, were impacted by locations where they were conducted. Not all respondents answered all questions, thus responses often do not total 43.

	1:1 Interviews (8 possible)	**Focus Groups (43 possible)**
Services Needed	**Number of Individuals Responding**	
Food: Free Meals, Food stamps	7	25
Transportation: Bus passes, gas voucher	6	26
Job training/employment services	2	8
Shelter day services	4	24
Legal assistance or Immigration services	3	9
Health services	6	21
Health insurance	2	11
Mental health services	5	14
Alcohol/drug counseling	5	5
Short-term Financial assistance (deposit assistance, arrears payment)	2	17
Veteran services	0	1
Disability income	2	11
Cash Aid: TANF, General Assistance	2	15
Comments	*Did not get needed MH services*	*Clothing, storage, immediate shelter (waitlists everywhere)*
Communications	**1-1 Interviews**	**Focus Groups**
Word of Mouth	3	√√
Homeless Resource Guide	0	√√
211	0	√√
Police	1	√
Agency Referral	5	√√√
Other resource guide	0	
Communications, cont'd.	**1-1 Interviews**	**Focus Groups**
Other	Face to Face (3);	Computer;

	Catholic Charities; Empowerment Center. Did not know who to call.	Resource guides outdated info; posting info in public places i.e., library, mini marts, mall, etc.
Referrals	**1-1 Interviews**	**Focus Groups**
Number of Inquiries prior to shelter	Range 2-40	1-2: 10 3-4: 9 5-9: 2
Able to follow up on referrals?	Yes – 5 No – 3	28 Yes
No access to a phone	3	√√√
Lack of transportation	6	√√√
Couldn't keep track of or prioritize referrals	4	√√
Didn't think I was eligible for their services	3	√√
Bad reviews of some places	0	√√
Other	Feeling overwhelmed	Sent to men's shelter as a woman (referred to wrong agency)
What would have helped to follow up?	Transportation - 4; phone/cell phone - 2; filing system/calendar - 1; intervention from family/friend/case worker - 2; mental health services - 1	Clear and concise information as most of us had little or no financial resource, wasting money to go to the wrong place is discouraging. Having an advocate or case worker to help keep track of referrals, help make calls, etc.
Would Co-located services help?	8 Yes	27 Yes 1 No
Do you have a way of staying in touch if wait-listed?	8 Yes	27 Yes 1 No
Preferred means of contact	**1-1 Interviews**	**Focus Groups**
Cell phone	5	√√√
Voicemail	2	√
Message left t program	3	√√√
Phone of friend or family member	2	√√
Preferred means of contact	**1-1 Interviews**	**Focus Groups**
Other	Email - 2	About half had a cell phone

		and the other half had a way to receive messages from a friend or agency.
What stopped you from following up after being contacted?	Active addiction – 1; Never contacted – 1; Not thinking he was qualified – 1; Sick – 1; Mental health issues (difficulty tracking) - 1	Drug testing Sobriety requirement Already found a place to stay
Do you have a cell phone?	6 Yes; 2 No	21 Yes; 7 No
Still hard to contact you even with a cell phone?	No	No
Where else can you access a phone?	6 Program site; 7 Friend; 2 Family	Program site √√√ Family member √
Documentation – Best ways to carry & keep safe	**1-1 Interviews**	**Focus Groups**
Have a way of tracking appointments?	8 (appointment cards in wallet – 1; cell phone – 2)	28 Yes
Best way to carry documents	Notebook/folder/binder/small accordion file – 5; Storage unit/family home - 2	Folder/accordion file √√√ Other: Agency keeps copies; lock-box someplace; back-up copies with family member/friend
Electronic documents on a flash drive (to keep on your keychain	Good idea – 3 Not good idea – 3 (might lose it; no computer skills)	Good idea √√ Not a good idea √√ (no access to computer; no computer skills)
Plastic accordion file for legal documents	7	√√√√ (noted as preferred method of all)
Service provider faxes all paper versions to referral	6	√√√√
Other ideas	Big envelopes get lost	
Trust, rules, concluding questions	**1-1 Interviews**	**Focus Groups**
What makes you not trust service provider with personal information?	No trust issues - 4	Labeling/judgment/stigma - √√ Identity theft (or fear of it) - √√ Unfamiliar environment - √
What situations make it easier for you to trust your service provider?	Confidentiality – 1 Help finding apartment – 1	Privacy, confidentiality, fairness, honesty, structure, cleanliness; outreach; help getting permanent housing as first step
Trust, rules, concluding questions	**1-1 Interviews**	**Focus Groups**

What rules have you heard about?	No active additions/sobriety – 5; No child abuse or sexual assault convictions – 1; No arguments or fighting – 1	Rules are confusing, staff not on same page, everyone tells you something different, lack of clarity; dedication to program, commitment, self motivation, no fraternizing, having to leave during the day; having to check in/out with program; no pets; sobriety/drug testing - √√
Do rules hamper your access to services?	Yes – 2; No – 5 (likes guidelines – 1)	Yes - √√√ No - √√
Rules that are barriers	Active addictions/drinking – 2	Lack of flexibility around real world situations i.e., work schedule conflict with curfews; drug testing; No pets; transportation; SSI decreased for being in a shelter
How willing are you to do an in-depth assessment?	Very willing – 5 Very willing if focus is permanent housing or a job – 1 Take it or leave it - 1	Very willing - √√√; Willing √ Everyone responded that if permanent housing was the priority of the service provider then they would be very willing to do an in depth assessment.
What should we have asked? About being ill and homeless: hard getting into a shelter (e.g. Nightingale) when I need it. Also I have had to voluntarily leave a shelter because I don't want to disturb others (talking at night, hearing voices; my schizophrenia) Would it be helpful to have an assigned case worker who helped coordinate all services and referrals?		

ATTACHMENT 6 – Narrative on Site Visit to Connecting Point, San Francisco

October 4, 2013

–Jenny Abramson, CoC Coordinator

We met with Program Director Elizabeth Ancker and Assistant Program Director Jacqueline Morales. I would say that in general this visit debunked a lot of the shiny "program model" myths generated by Tony Gardner's white paper. In practice it's much messier and less functional than we'd imagined.

Compass Family Services is a nearly 100-year old agency, and has been providing "coordinated intake" —really waitlist case management—for San Francisco's Family Shelter Consortium at its drop-in center in the Tenderloin (6th & Market) since the late 1990's. Connecting Point only provides this service for families with children looking for entry into "long-term" shelters with a 3-6 month stay. The Family Shelter Consortium is made up of the publicly funded shelters, and there is cooperation with privately funded ones (who also do some direct, onsite intake). All of these are distinguished from the "emergency shelters" where families can stay on a one-night or other short-term basis. As such Connecting Point manages the City's waitlist, which consists of about 270 families, typically a 5-7 month wait. Current staff members have been there since 2007 and 2010, so no one was available to speak about the project's start-up phase.

Single adult system entry is still "large and messy" – there is a big network of shelters and a very problematic system of 9 reservation stations around the city. Instead of waiting in line for a bed at a shelter, the reservation system forces single adults to wait at a different location for a one-night stay. That is, every night, every single adult has to stand in line for a one-night stay.

Connecting Point provides both drop-in and phone-in services, but getting on the waitlist is exclusively by phone. Therefore if someone comes for one of their 3 weekly drop-in sessions, they are assisted to make the phone call onsite (to their own office). This is an 8-10 minute eligibility screening call. At the end of the call they make an appointment for a 1-hour full intake, typically within 2 weeks (not always possible due to demand and inadequate staff). About 1 in 3 families show up for their appointments; about one-third of those who come in for their interview eventually present to either a shelter or other housing.

Clients are required to check in weekly either by phone or in person. Case management is primarily crisis-oriented, and they attempt to link people with all kinds of other services (including the Eviction Defense Collaborative, located in the same building). Clients stay in a combination of hotels, cars, "emergency" shelters, and couch-surfing while on the waitlist. Because the number on the waitlist has increased drastically since the recession, there are priorities for more vulnerable families with medical concerns (including pregnancy) or a mental health issue. They use GAF scores as a guideline, prioritizing families with scores of 40 or lower. They have a clinician on their agency

staff who will write letters documenting the priority if needed, but they try to make sure the family is connected to treatment and a letter can be provided by that practitioner.

Connecting Point staff is made up of the Program Director, Assistant Program Director, 6 case managers, a receptionist, 3 housing specialists and numerous interns. The housing specialists operate an eviction prevention and rental assistance program, diverting about 100 families per year from the shelter system.

Representatives from all the participating shelters meet in person every Wednesday morning to determine placements off the waiting list. The shelter program models are more or less the same – most of the decisions are logistical, based on who has the right-sized or wheelchair-accessible room available. City policy is all shelters are behavior-based (not really harm-reduction): clients cannot use drugs or alcohol on site, but they may enter under the influence.

The Shelter Consortium placement meeting is also attended by a Public Health Nurse who helps interpret the "medical priority" documentation. Placement is now almost exclusively from the priority list. There are heated discussions with providers advocating for their clients or refusing to take families who had problematic behavior or outcomes in the past. The discussion includes contingency plans if families being accepted into shelter cannot be found. If even the family in the contingency plan cannot be found, Connecting Point staff are authorized to make placement without further consultation.

As a family moves up the waitlist, much effort is expended to ensure the family is reachable when a room opens. Once the placement is assigned, the room is held for 24 hours, and Connecting Point makes up to 4 attempts to reach the family. If they cannot reach the family, they are considered a "no show," dropped from the list, and have to start all over again. (Many people have cell phones but are still unreachable – out of minutes, no place to charge the phone, etc.) If they cannot be found in 4 attempts, Connecting Point staff attempt to reach the "contingency" family. Assuming a family is reached, the shelter then calls them by phone as well, to prepare them for entry. No actual physical, in person warm handoff takes place. All documents and case notes are scanned and emailed to the shelter (they maintain a record of their decisions, contingencies, and the waitlist on Google-docs). The shelter then does its own intake after the person arrives.

There are currently no residency requirements, and though working only with San Francisco shelters, Connecting Point receives calls from all over the inner Bay Area (few from the north though). There is a lot of client sharing across county lines from San Francisco east and south. The lack of residency requirements is now a subject of much controversy, with the City trying to implement a residency requirement (the date has been pushed back several times already).

From the program's viewpoint, they are funded by a HUD CoC grant and City funds (likely a combination of ESG and general funds). They report to the City, and will send me a sample report. Their CoC reporting is the APR, which they find very problematic for reporting outcomes (the housing outcomes are the wrong ones). They say they place about 65% in housing, including about

20% who go into transitional housing – this leaves about 45% who go to permanent housing, including from their rental assistance program. It sounds like this data cohort includes all who do the intake interview.

They do not have adequate or integrated database systems. Their rental assistance program is in EtO, but everything else is in antiquated, separate databases and spreadsheets. This includes their CoC reporting, which is apparently not coming directly out of the web-based HMIS. They talk about having to massage the data a lot prior to reporting due to data quality issues. None of their data is integrated with anyone else's. There is essentially nothing to learn from them in this area. There is discussion of tech-based solutions, but nothing happening yet.

Even though the staff members we visited have not been there since the program's inception, I asked them to talk about the changes they have seen and adjusted to. Primarily it's the expansion of the waitlist from a few dozen families to hundreds, and from a 2-month wait to much longer, that have brought changes. The first wave of publicity about the expanding waitlist brought the medical priorities into focus and resulted in the addition of the rental assistance/diversion program. The second wave in the last year has brought the new discussion of residency requirements and stricter time-out rules.

ATTACHMENT 7 – Coordinated Intake Workgroup Decision Log

This table indicates the input and decisions made by homeless service provider members for the period of September 2011 through July 2014.

Issue	Decision/Date
Why do this? What would be the benefits? What are the specific project goals or objectives?	
Assist in achieving HEARTH system-wide goals – early triage and immediate, accurate referral; diversion of people from long term stays; immediate PH planning Save time in assessing needs at every stage – impact length of homelessness	Goal designed via HEARTH Outcomes group Spring 2011
Mission of planning group: *Design a coordinated system for triaging homeless persons upon entry to the Continuum that results in their efficiently receiving the individualized services/resources that would reduce the length of time they are homeless. Design should include policy & practice recommendations deemed necessary to support effective implementation of such a system.*	September 2011
Eligibility already assessed when the client arrives – enable case managers to focus on addressing (rather than assessing) needs	Fall 2011
Problem Identification: What are the key challenges we hope this system will address?	
Which populations will be targeted? Development of 4 client profiles for different needs: ▪ Unmotivated, homeless "by choice" with multiple issues ▪ Disabled with physical, mental health, alcohol/ drug, trauma, domestic violence – and seniors. ▪ Economically fragile, often large families, on the edge, earning capacity limited to minimum wage, have lost job and home ▪ Motivated, working or recently unemployed, employable with skills	October 2011; analysis of 2011 HMIS data for family vs. single adults in these 4 groupings, completed February 2012
Model Design	
Centralized, Centralized Telephone, or Decentralized Model? **Decentralized** (e.g. Alameda County in NAEH materials) – Housing Resource Centers (co-located with other services) plus 211, common assessment, monthly in person meetings and online communications.	September 2011
Multiple Location Uniform Intake In support of an "any door" services strategy, clients may call or go to any one of multiple participating prevention and homeless programs at different geographic locations. Intake workers at each location use standardized intake, assessment, and referral procedures and tools, often in the context of shared HMIS data collection and reporting. **211 Phone Centralized Intake** In an "anywhere" services contact strategy, clients call 211 or another hotline number to request assistance. Phone intake workers use standardized procedures and tools to conduct first level screening and/or referral, often in the context of shared HMIS data collection and reporting. Typically, the receiving program conducts additional assessment and verification and makes final admissions decisions.	December 2011 *Language to left is from HUD planning document, but accurately describes decisions made.*
Method of client contact: ▪ Initial contact can be by phone or walk-in; some programs begin with phone contact followed by in-person appointment ▪ Contact by phone followed by referral to an in-person meeting or appointment with the receiving program	November 2011

Issue	Decision/Date
Depth of client contact ▪ Face to-face meeting allows for more in-depth client contact/assessment ▪ Phone meeting is usually brief, with more in-depth client contact/assessment by the receiving program	November-December 2011
On-site services ▪ On-site services (vouchers, food, etc.) are possible, and often co-located with other service programs ▪ On-site services are typically not possible with phone-in service Client information and referral, program screening and assessment, and crisis intervention and de-escalation. Data collection and processing, both for client and program information. If the project provides prevention programs, rental assistance and housing-related case management could actually be delivered on-site. Family-focused programs may want to provide additional family services, such as childcare and parenting programs. Some centralized intake programs also furnish basic or emergency services, such as bus tokens or toiletries.	Live data entry, Spring-summer 2014 Per HUD contract, any prevention assistance must be provided with non-CoC funds (summer 2014).
Facilities ▪ Intake is integrated into existing programs, should be disability accessible, close to public transportation, with space for confidential meetings ▪ Need a call center with space for one or more phone workers; should have interpretation for language accessibility	To be included in RFQ
Hours of operation ▪ Depends upon resources for staffing; evening and weekend hours improve client access	24/7 coverage via 2-1-1
Staffing/caseload ▪ May need to hire and train new intake staff with housing assessment skills ▪ Likely can implement with existing program staff who may need training on uniform procedures ▪ May be implemented with existing 211 or other hotline staff, but need to train for or hire a housing specialist	To be included in RFQ
Cost ▪ Staff, facility, and other costs may be absorbed in existing programs, some efficiencies may be lost ▪ May need to pay a share of existing 211 or pay additional costs for a housing specialist	
Written policies and procedures that spell out programmatic roles, responsibilities, and expectations of all staff, to make the program effective and efficient.	To be included in RFQ
<u>What resources are needed to implement?</u>	To be included in RFQ
<u>How will ongoing collaboration with stakeholders be supported?</u> Regular process for communication and input, especially programs receiving admitted or referred clients. Advisory committee? Regular conversations with centralized intake management and staff.	CI Workgroup to continue as Advisory Committee.
Role of HMIS: How will data be effectively managed?	
Open HMIS system	September 2011
Assessments & decision trees	
Critical questions to distinguish 4 profiles:	November 2011

Issue	Decision/Date
Key things we need to know for ▪ Prevention/diversion resources, referral to shelter if ineligible for prevention/diversion ▪ Review of options outside shelter and outside Sonoma County ▪ Immediate linkage to appropriate services ▪ Shelter assessment for rapid re-housing (use RRH Triage Tool & Eligibility Screening to develop a common set of agreed-upon assessment and targeting tools). Rapid Exit assessment within 72 hours. ▪ Review of barriers to retaining PH ▪ Shelter entry as the last option ▪ Shelters develop a permanent housing plan ASAP, services focus on PH plan, links to community-based services. ▪ Assessment/referral to more intensive services – mental health treatment, AOD treatment, transitional living.	Ideal service flow & screening questionnaire developed December 2011-June 2012
Coordinated effort to build relationships with landlords, creation of resources to quickly get people back into housing	Strategy adopted by HEARTH Outcomes group, spring 2011. Ongoing via RRH and PSH providers
<u>Process for screening, assessment, and verification</u> Level and mix of information needed will vary depending upon such factors as whether program admissions decisions are being made or not, types of programs and services offered, priority and eligibility criteria, whether client contact is face-to-face or by phone, HMIS requirements, and other legal or funder requirements.	Use of VI-SPDAT and SPDAT tools prior to placement, spring 2014.
Level of Authority for Housing Admissions	
First-level Screening, flagging further assessment needed (to be conducted by designated experts): *The goal of the front door screening is to distinguish the groups A, B, C and D as quickly as possible, and once the general grouping is determined, to assess their needs well enough to make an accurate referral. Therefore the initial screening should be structured to ask only the critical questions needed to determine which general profile is appropriate, and to trigger assessment modules for each profile.*	November 2011
Mixed Admissions Authority depending on accepting agency's contract requirements.	Under discussion
Memorandum of Understanding (MOU) or other formal interagency relationships	Under discussion
Shelter Waitlist management desired?	Yes, fall 2013.
Specific procedures should govern how staff make, follow-up, and document program admissions and referrals	Under discussion
Process for refusal of services	Under discussion
Staff preparation for changes to intake process	Under discussion
Identification and elimination of "side doors"	
Community resource mapping	
Existing resources: Housing Inventory; 211 directory	
Participating agency strengths/core competencies, eligibility, current referral sources. Are these tied to contracts? Will they join with centralized process?	Under discussion through Program Standards Development
Other information needs – A regularly updated information and referral database, preferably linked to HMIS. 211 database into HMIS for referral?	

Issue	Decision/Date
Training needs	
Multi-Phase Plan for rollout	Beta-test with families fall 2014
Training plans – this is a 6-month rollout, will require an implementation plan with a few key players over the following 6 months, then refer into QA committee for monitoring and evaluation	
Lead Agency	
Who will be the lead agency? It is important to select a lead agency with the capacity and legal authority to manage the project as envisioned, as well as the ability to gain the trust of and collaborate with other agencies. In selecting a lead agency, consider: 1. Prior experience in relevant hotline, intake, and eligibility screening processes; 2. Background in crisis intervention; 3. Previous experience working with the target client population, e.g., homeless youth; 4. Proven ability to use and maintain data systems for managing client data, program information (e.g., shelter bed openings), and client referrals; **5.** Strong management and fiscal capacity	To be determined via RFQ
Publicity	
How will clients know about centralized intake? Street outreach Service site outreach Informational flyers, wall postings, Radio and television public service announcements, Announcements during CoC or other coalition meetings Website postings. Other agencies that will likely refer clients, especially agencies that already serve clients with housing crises (who are somewhat pre-screened)	Ideas drafted in 2012 CoC application; To be included in RFQ

ATTACHMENT 8 – Coordinated Intake Release of Information Form (Participant ROI)

The Client Release of Information Form was designed by the HMIS Coordinator, discussed by the CI Workgroup and approved June 2014 by Joanne Borri, County of Sonoma Privacy Officer.

Sonoma County Continuum of Care

Homeless Coordinated Intake Program

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Overview: The Sonoma County Homeless Coordinated Intake Program provides a single access point to over 140 shelter and housing programs throughout the county, which reduces the work families and individuals must do to locate housing or shelter and move out of homelessness.

Use of Confidential Information: The purpose of this Release of Confidential Information consent form is to allow the Sonoma County Continuum of Care Coordinated Intake (CI) Program to use information you provide to assist in procuring housing/shelter placement and provide support services for you and your family. In order to enroll you and your family in the CI Program, we need to collect some personal information from you as the head of your household. When housing resources become available you will be notified about the referral(s) being made.

While you are enrolled in the CI Program, Coordinated Intake staff will have access to your confidential information. In addition, should you and your family be referred to a Sonoma County homeless service agency/program for housing placement, that agency will be afforded the information you have provided.

Unless you stipulate otherwise, your confidential information will only be forwarded to Homeless Management Information System (HMIS) Participating Provider. The HMIS is a HIPAA compliant online database. All staff and administrators with access to the HMIS observe rigorous client security and ethical standards as mandated by the federal Department of Housing and Urban Development (HUD) and the Sonoma County Continuum of Care HMIS Quality Assurance workgroup. HMIS users are re-certified in Client Security and Ethics on an annual basis.

Your information will not be provided to any other party unless specifically outlined and agreed to in an addendum to this form, except for situations where a threat exists of harm to yourself or other persons.

*(**Note** If you ever have reason to believe your confidential information in the Sonoma County HMIS has been misused, you should immediately contact the Sonoma County Continuum of Care HMIS Coordinator by emailing hmis@sonoma-county.org or calling the Community Development Commission at (707) 565-7500)*

Disclosures and Period of Enforcement: The release I am signing will be in effect for a period of two years from the date of signed authorization by you. Should you refuse to sign this consent, you and your family may not be refused service, however by allowing the homeless providers you work with access to this information, a more relevant case plan will be able to be created to assist you.

Specifically the information you provide will be considered active until one of the following events occur:

1. The Release of Confidential Information lapses after a period of two years
2. You return to the Coordinated Intake Program with a new request to obtain shelter/housing services
3. You (at any time) formally request this Confidential Release of Information be revoked

Sonoma County Continuum of Care

Homeless Coordinated Intake Program

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Provisions of this Release of Information: By providing my consent I am allowing Coordinated Intake Program staff to provide case management and housing placement services and share my information with Sonoma County HMIS Participating Providers where I and my family have been referred for service.

I, _____, (full name) and/or

_____ (alias) on this day of _____

as head of my household, authorize the Sonoma County Homeless Coordinated Intake Program to collect and share the following information with HMIS Participating homeless service providers to whom I have been referred for housing, shelter or other homeless service:

- Client Demographics including full name, DOB, SSN, Race, Ethnicity (see attached)
- Confidential information gathered during the Sonoma County VI-SPDAT for Families assessment process (including health and personal finance information – see attached)
- The shelter and/or housing program(s) preference my family has expressed interest in
- The date my family was placed on the Coordinated Intake Family Wait List for shelter and/or housing

The list of Sonoma County Homeless Service Providers who may have access to your information (upon acceptance into their program) is below. I understand additional agencies may join the Coordinated Intake system at any time and upon my request I will be provided a current list of those partner agencies.

Agency Name	Acronym
Buckelew Programs	BUCK
Catholic Charities of the Diocese of Santa Rosa	CC
Cloverdale Community Outreach	CCOC
Committee on the Shelterless	COTS
Community Action Partnership	CAPS
Community and Family Service Agency	CFSA
Community Support Network	CSN
County of Sonoma Human Services	HSD
Drug Abuse Alternatives Center	DAAC
Interfaith Shelter Network	IFSN
Legal Aid Sonoma County	LASC
Petaluma People Services	PPSC
Redwood Gospel Mission	RGM
Santa Rosa Health Centers	SRHC
Sonoma County Housing Authority	SCHA
Social Advocates for Youth	SAY
Sonoma Overnight Support	SOS
The Living Room	TLR
Veteran's Resource Centers of America	VRCOA
Volunteer Center of Sonoma County 211	211

Sonoma County Continuum of Care

Homeless Coordinated Intake Program

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

SIGN BELOW IF AGREEING TO BE ENROLLED AND ASSESSED

Your signature (or mark) indicates that you have read (or been read) the information provided above, have had all your questions satisfactorily answered and agree to provide information for the purpose of enrolling in the Sonoma County Homeless Coordinated Intake Program.

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Unless revoked in writing, this release of information is valid for a period of two years from the date of Coordinated Intake program enrollment.

_____ _____

SIGNATURE OF HEAD OF HOUSEHOLD DATE

TO BE COMPLETED BY THE Sonoma County Homeless Coordinated Intake Program

Please write clearly to ensure accuracy

Head of Household's Name/Alias: _____

Date enrolled in the Coordinated Intake Program: _____

The program(s) your family expressed interested in being referred to:

ATTACHMENT 9 – Coordinated Intake Screening Tool Developed by CI Workgroup

This questionnaire was developed through the Coordinated Intake Workgroup sessions and served as a basis for later adoption of the evidence-based VI-SPDAT and SPDAT tools.

Sonoma County Continuum of Care – Coordinated Intake Screening Draft #7

[PHONE SCRIPT:] **SAFETY:** Are you in a safe place right now? Unsafe ☐ In danger? ☐ ***See EMERGENCY SCRIPTS.***
Can you talk freely? ☐ Yes ☐ No: If not Unsafe/In Danger, make walk-in referral

1. **REASON FOR YOUR CALL/VISIT?** Called 211? ☐
2. **GEOGRAPHIC LOCATION:**
3. **NUMBER IN PARTY:** Are you looking for help for yourself or someone else? Does this involve more than one person? How many? (Family? Children (ages)? Partner?)
4. **NAME:**
5. There are different resources for adults vs. youth, so I need to ask your **AGE?**
6. **Have you served in the military?** ☐ Veteran If a veteran: what was your discharge status?
7. **HOUSING STATUS: Where did you sleep last night?** Briefly, what led to this situation? How long in this situation?

CLEARLY HOMELESS:

☐ **Unsheltered** – in a place not meant for human habitation (car, van, tent, abandoned building, street, unconditioned space, e.g. unfinished garage)
☐ **Shelter** (Which?) Not applicable
☐ **Transitional housing** (Which?) Not applicable
☐ **Hotel with voucher** – *Arranged for you by an agency?*
☐ → HOMELESS Who arranged it?
Paid by self or family? do not check here, see ***Presumed At Risk***, at right.
☐ **Fleeing Domestic Violence,** No place to go & no resources to find other housing (confirm with ***Diversion Questions***, below right) → HOMELESS

PRESUMED "AT RISK" *(30% AMI requirement to be confirmed below):*

☐ **Living in Hotel** paid by self/family
☐ **Adults >25 couch-surfing** (2+ moves in past 60 days) or staying with friends/family with no resources to find housing
☐ **Youth <23**, no safe place with family
☐ **Runaway or abandoned children <18**
☐ **Youth/Child or parent of children** couch-surfing, living in hotel/campground but not meeting "2 moves in 60 days" rule

FURTHER INQUIRY TO DETERMINE HOUSING STATUS:

☐ **Institution** (jail, prison, hospital, foster care, psychiatric unit, or drug rehab) *How Long? & Where did you stay before that?*
☐ < 90 days & Unsheltered/Shelter →HOMELESS
☐ >90 days or other living situation before → AT RISK
☐ **Losing Housing with no place to go** *How soon do you have to be out? Where are you thinking of going?*
☐ **Within 14 Days** (Imminent Risk), no place to go & no resources (see Diversion Questions, at right) → HOMELESS
☐ **15-21 Days**, no options identified → AT RISK
☐ **>21 Days** → NEITHER HOMELESS NOR AT RISK
☐ Have you received notification from the landlord?
☐ **Couch-surfing Youth <25 or families with children <18.** *How long since you had a home? For the past couple of months, where have you stayed? Have you had to move in the last 2 months? How many times? Why has it been so hard to find a place to stay?*
☐ At least 2 moves in past 60 days + disabilities or other barriers to work → HOMELESS
☐ <2 moves in past 60 days OR can work →AT RISK

DIVERSION QUESTIONS: *What other options do you have?*
Is there anyone you could stay with for 3-7 days if we get you some help from a case manager?
Could you pay for a hotel room just for a couple of nights while we get you some help resolving this crisis?
☐ Yes ☐ No
Temporary Destination:

Are you from Sonoma County? ☐ Yes ☐ No
If not, where are you from? Hometown:
Is there anyone back there still? If we could help you get back, would you want to go?
Wishes to return ☐

Past evictions? ☐
How many evictions? *Circumstances?*

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8. Are you working with any other agencies? ☐ Yes ☐ No Who are you working with there? (Contact info?)

9. **FINANCIAL:** Have you had any income in the past 30 days?

INCOME: ☐ YES	**INCOME: ☐ NO**
☐ Working *How many hours/week?* *How much do you earn?* per Hour ☐ SonomaWORKS Monthly ☐ Disability Income Monthly (explain) ☐ Other Income per Hour (explain) Total Monthly Income % of AMI Below 30% (refer to AMI chart on p. 4) Bank Accounts ☐ Yes ☐ No Savings balance: Checking balance:	**ABLE TO WORK?** ☐ YES ☐ NO *If Yes: Tell me about your work history: Skills? Plan for employment?* *How much did you last earn on a monthly basis?* If No: **DISABLED** ☐ (If not, see **Not Disabled** below) Describe disability: How long have you had the disability? [If >1 year:] Documentation of disability ☐ *Applied for SSI?* ☐ *Status of application?* *Applied for GA/TANF?* ☐ **NOT DISABLED**: other reason unable to work:
10. Highest level of education completed *Did not finish HS* 11. *Long-term goals for increasing income?*	12. Ever convicted of a crime? ☐ Yes ☐ No How many times? What for?

HEALTH SCREENING: *This won't take much longer, but we need to ask some private questions about your health to make sure we get you the help you need. Is that okay?* [☐ Check & continue if consent is given.]

13. Do you have any urgent health needs right now?
If interviewing by phone, you may skip to Q27 and make initial referral.

14. Have you been to the emergency room in the past 3 months? ☐ How many times? 15. Hospitalized as an inpatient in the past year? ☐ How many times? 16. Do you (or your children) have any chronic health problems? ☐ Taking any medication? 17. Prescription meds? ☐ What for? Medications you should take but don't have ☐ 18. Do you have a permanent physical disability that limits your mobility? ☐ 19. Have you been the victim of a violent attack since you've become homeless? 20. Do you feel safe in who you are living with? ☐ Yes ☐ No History of intimate partner violence? ☐ How about **right now**?	22. Have you been diagnosed with any of these medical conditions? ☐ Kidney disease/ End Stage Renal Disease or Dialysis ☐ Frostbite, Hypothermia, or Immersion Foot ☐ Heat Stroke/Heat Exhaustion ☐ Liver disease, Cirrhosis, or End-Stage Liver Disease ☐ Heart disease, Arrhythmia, or Irregular Heartbeat ☐ Emphysema ☐ Diabetes ☐ Asthma ☐ Cancer ☐ HIV/AIDS ☐ Hepatitis C ☐ Tuberculosis 23. How about your mental health? Are you hearing voices? ☐ Have you ever been hospitalized for emotional problems? ☐ 24. Any history of violence in the past 2 years?

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21. Have you ever tried to hurt yourself? ☐
Should I be concerned about you **right now**? ☐
(If **right now** is checked, see **Emergency Scripts**)

25. Certain places are stricter about drug/alcohol use. So I know how to refer you: would you pass a UA test today? ☐ Yes

☐ No: *There's always room at Orenda Detox. Would you be open to staying there for a few days so you can get into a clean & sober shelter?*

26. When did you last drink alcohol? [Before that?]

27. To make sure we don't mix you up with someone else: do you know the **last 4 of your SSN**?

28. **RACE/ETHNICITY:** For our reporting, please tell me: Are you Hispanic? What Race(s) do you identify with?

Ethnicity	**Race (Mark all that apply)**
☐ Hispanic or Latino	☐ White
☐ Not Hispanic or Latino	☐ Black or African American
	☐ Asian
	☐ Mexican or American Indian or Alaska Native
	☐ Native Hawaiian or Other Pacific Islander

30. Can I get your full **DATE OF BIRTH** too?

RELEASE OF INFORMATION: I can pass all this information on to , where we'll refer you. Sign to indicate your agreement.

Signature: _____

Contact info: Phone Email

☐ Signed Release of Information on file.

STAFF USE ONLY BELOW THIS LINE

Based on previous questions, mark the appropriate responses:

CURRENT HOUSING STATUS

☐ Homeless ☐ At Risk of losing their housing ☐ Stably housed ☐ Don't know ☐ Refused

VULNERABILITY ASSESSMENT: ☐ Homeless more than 6 months (Q6) **PLUS** one of the following:

a. ☐ HIV/AIDS (Q24)
b. ☐ Liver Disease/Hep C/Cirrhosis/ESLD (Q24)
c. ☐ Kidney Disease/ESRD/Dialysis (Q24)
d. ☐ Cold weather injuries (frostbite, hypothermia etc.—Q24) OR
e. ☐ TRI-MORBIDITY: must have all of the following: ☐ Mental Health (Q23 & Q24) + ☐ Substance Abuse (Q25 & Q26) ☐ Other serious medical condition (Q18 & Q22)
f. ☐ 60+ years of age (Q5)
g. ☐ 4+ hospitalizations/ER visits in past year (Q16)
h. ☐ 4+ ER visits in past 3 months (Q15)

If Homeless >6 months AND any of a-f checked, mark HIGH PRIORITY DUE TO VULNERABILITY on next page.

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HOUSEHOLD INCOME ELIGIBILITY: ☐ No income ☐ 1-30% AMI ☐ 31-50% AMI ☐ >50% AMI

Family Size	Below 30% (Extremely Low)	31% to 50% (Very Low)	Over 51%
1	Below $1,450 /m	$1,451 to $2,413 /m	$2,414 /m & above
2	Below $1,654 /m	$1,655 to $2,754 /m	$2,755 /m & above
3	Below $1,863 /m	$1,864 to $3,100 /m	$3,101 /m & above
4	Below $2,067 /m	$2,068 to $3,442 /m	$3,443 /m & above
5	Below $2,233 /m	$2,234 to $3,721 /m	$3,722 /m & above
6	Below $2,400 /m	$2,401 to $3,996 /m	$3,997 /m & above
7	Below $2,567 /m	$2,568 to $4,271 /m	$4,272 /m & above
8	Below $2,729 /m	$2,730 to $4,546 /m	$4,547 /m & above

DISPOSITION OF THIS PERSON: ☐ **High priority due to vulnerability**

☐ Eligible for shelter and referred: (none), (none)

☐ Eligible for Rapid Re-Housing and referred: (none), (none)

☐ Eligible for transitional housing and referred: (none), (none)

☐ Eligible for permanent supportive housing and referred: (none), (none)

☐ Employable: ☐ Skilled ☐ Needs training ☐ Other (describe)

☐ Unable to work: ☐ Disabled ☐ Young children ☐ Other (describe)

☐ Disabilities: ☐ Physical/Chronic Health problems ☐ Developmental Disability

☐ HIV/AIDS ☐ Mental Illness ☐ Substance Abuse

☐ Other (describe)

☐ Ineligible for homeless services: ☐ At Risk ☐ Stably housed **Refer to 2-1-1**

☐ Eligible and referred to prevention services: (none)

Ineligible for prevention services: ☐ Stably housed ☐ Income above 30% AMI

☐ Transportation needed to access referral:

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Key Referrals

EMERGENCY SCRIPTS:

IF **FLEEING DOMESTIC VIOLENCE**: 24-hour crisis line: **546-1234** to plan an exit strategy. If in immediate danger, call **911.**

OTHER EMERGENCIES: Call **911** from a land line. For cell phones call **528-5222** (Santa Rosa Police) or **565-2121** (County Sheriff); ask them to evaluate for a 5150

IF ATTEMPTING SUICIDE: North Bay Suicide Prevention Hotline, **(855) 587-6373**

How? (Pills/weapon)
IF PILLS: What kind of pill? How many? Dosage? What time did you take them?
IF WEAPON: What kind of weapon? Where is the weapon?

OTHER MENTAL HEALTH CRISIS:

- Do you/they have a Mental Health Diagnosis?
- Is the person threatening to harm self?
- Is the person threatening anyone else? Please describe specific behavior
- Are they on or off medication? For how long?
- Are they on drugs or alcohol? What is the history of use?
- Is there a history of violence? (Please explain)
- Not threatening violence: If something is very wrong, please explain specific behavior.

IF CLIENT IS <18, call SAY Outreach staff: 24-hour emergency hotline at **(800) 544-3299** or send them to the Dr. Coffee Teen Shelter anytime: **1243 Ripley St., Santa Rosa**.

VETERANS: Refer to the North Bay Veterans Resource Center, **578.VETS**. One-stop veterans' services are available weekly at Sonoma County Vet Connect, Tuesday mornings, SR Vets Building, 1351 Maple St, Santa Rosa; 2nd Thursday afternoons at the Guerneville Vets Building, 1st & Church Street, Guerneville. Vet Connect can also be reached at **536-1656**.

EMPLOYMENT REFERRALS:

Highly skilled: Sonoma County JobLink, **565-5550**, 2227 Capricorn Way, Suite 100, Santa Rosa

Disability-related employment services: Goodwill, **523-0550**

All Others: in Santa Rosa: Coach 2 Career, **542-5426.**

PRESUMED DISABILITY AND ALL OTHER HEALTH REFERRALS: Brookwood Health Center **583-8700**, 983 Sonoma Avenue Santa Rosa. In Petaluma, the Mary Isaak Center: **765-6530**.

NON-EMERGENCY DOMESTIC VIOLENCE ISSUES: call the YWCA's 24-hour hotline, **546-1234.**

ATTACHMENT 10a, b & c – VI-SPDAT Screening Tool for Individuals and Families

This VI-SPDAT tool has been developed as a collaborative effort between the nationally recognized Community Solutions group who designed the 100,000 Homes Campaign, and OrgCode Consulting, Inc., a Canadian research firm specializing in strategy, planning, training and research for homeless service providers.

The VI-SPDAT is a "supertool" that combines the strengths of two widely used existing assessments: The Vulnerability Index (VI), and the Service Prioritization Decision Assistance Tool (SPDAT). Based on a wide body of social science research and extensive field testing, the tool helps service providers allocate resources in a logical, targeted way.

The VI-SPDAT assessment will be used to conduct the first level screening conducted by 2-1-1. It will viewable by the Coordinated Intake Program staff and used in combination with the full SPDAT tool. The full SPDAT assessment will be taken at a more in-depth appointment scheduled with the CI case management staff. To view the most recent version of the full SPDAT, see: http://sonoma-county-continuum-of-care.wikispaces.com/Coordinated+Intake+Task+Force.

Together the resulting scores on these tools will be used to assign the participant households to the most appropriate housing service placement.

See more at: http://100khomes.org/blog/introducing-the-vi-spdat-pre-screen-survey#sthash.XSAj5IPs.dpuf

Attachment 10a – VI-SPDAT Demographics as shown in EtO HMIS

Add Participant:

Participant Information

Case Number:	
***First Name:**	
***Last Name:**	
Sono - Participant Nickname:	
***SSN:**	
DOB:	-Month- -Day- -Year-
***Sono - Gender:**	--Select--
***Sono - Primary Race:**	--Select--
***Sono - Ethnicity:**	--Select--
***Sono - Citizenship Status:**	--Select--
***Sono - Veteran:**	--Select--
***Sono - Disability Status:**	☐ Yes ☐ No
Sono - Language:	
Sono - Date of First Arrival Sonoma County:	-Month- -Day- -Year- today | +1 | +7 | +30 | +90
Sono - Date of First Homelessless:	-Month- -Day- -Year- today | +1 | +7 | +30 | +90
Email:	
Sono - Contact Phone:	
Alert:	
***Sono - Participant Interview Consent:**	○ Yes/True ○ No/False
Sono - Participant Image Consent:	○ Yes/True ○ No/False
Sono - Participant Image:	Browse... Caption/Description:

Program Enrollment Information

Enroll in Program:	☑ Sono - Vulnerability Index Survey
***Program Start Date:**	May 20 2014

Add Participant

Attachment 10b – VI-SPDAT Screening for Individuals

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)
Prescreen for Single Adults

Consent for Interview

We are here today to talk to you about your housing and service needs. All of the information we collect is completely confidential. Your location will not be shared with law enforcement. We are doing this study to find out about the health status of homeless people in Sonoma County, so we can design services to better help people.

If you give us permission, we will ask you some questions today for about 10 minutes and take a picture of you so we can identify you at a later date. These questions are about your health and housing and we will also ask for your social security number. By participating in the interview you give permission to the Sonoma County Continuum of Care to provide your information to authorized agencies for the purpose of furthering services and housing in this community.

Some of the questions we ask might make you feel uncomfortable or be upsetting. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break or to skip any of the questions. The information that you tell us during the interview will be stored in a secure database and also be shared with outreach workers and case managers who will follow up with you for services. All of your information will be kept secure and individuals who will see it have signed confidentiality waivers and will not share your information. You can skip any questions you do not want to answer, end the interview at any point, or choose to not have your picture taken. At anytime you can request that your information be removed from the database. We will give you a $5 food card at the end of the interview to thank you for your time. No one will be upset or angry if you decide not to be interviewed today.

SIGN BELOW IF AGREEING TO BE INTERVIEWED
Your signature (or mark) below indicates that you have read (or been read) the information provided above, have gotten answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

_____ _____
Date Signature (or Mark) of Participant

_____
Printed Name of Participant

Please sign here if you also agree to have your picture taken: _____
Signature (or Mark) of Participant

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

GENERAL INFORMATION/CONSENT

Interviewer's Name		Team #: ☐ Staff ☐ Volunteer ☐ Consumer Guide
Date	Time	Location
In what language do you feel best able to express yourself?		
First Name		Last Name
Nickname		Social Security number
How old are you?	What's your DOB?	Has Consented to Participate ☐ Yes ☐ No

A. HISTORY OF HOUSING & HOMELESSNESS

QUESTION	RESPONSE	REFUSED
A1. What is the total length of time you have lived on the streets or in shelters		☐
A2. In the past 3 years, how many times have you been housed, and then homeless again?		☐

B. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when 6 months ago was, just let me know.

QUESTION	RESPONSE	REFUSED
B3. In the past 6 months, how many times have you been to the emergency room?		☐
B4. In the past 6 months, how many times have you had an interaction with the police?		☐
B5. In the past 6 months, how many times have you been taken to the hospital in an ambulance?		☐
B6. In the past 6 months how many times have you used a crisis service, including suicide prevention or another crisis hotline?		☐
B7. In the past 6 months, how many times have you been hospitalized as an inpatient? Including in a mental health hospital?		☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

QUESTION	RESPONSE		REFUSED
B8. Since becoming homeless, have you been attacked or beaten up?	YES ☐	NO ☐	☐
B9. Threatened, or tried to harm yourself or anyone else in the last year?	YES ☐	NO ☐	☐
B10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?	YES ☐	NO ☐	☐
B11. Does anybody force or trick you to do things that you do not want to do?	YES ☐	NO ☐	☐
B12. Ever do things that may be considered to be risky? Like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, anything like that?	YES ☐	NO ☐	☐
B13. I'm going to read types of places people sleep. Please tell me which one that you sleep at most often. (Check only one.)	☐ Shelter ☐ Street, sidewalk or doorway ☐ Car, Van, or RV ☐ Park, beach, camping ☐ Other (SPECIFY:)		

C. SOCIALIZATION & DAILY FUNCTIONS

QUESTION	RESPONSE		REFUSED
C14. Is there anybody that thinks you owe them money?	YES ☐	NO ☐	☐
C15. Do you have any money coming in on a regular basis? Like a job, government benefits, or even working under the table, recycling, sex work, odd jobs, day labor, or anything like that?	YES ☐	NO ☐	☐
C16. Do you have enough money to meet all of your expenses on a monthly basis?	YES ☐	NO ☐	☐
C17. Do you have planned activities each day other than just surviving, that bring you happiness and fulfillment?	YES ☐	NO ☐	☐
C18. Do you have any friends, family or other people in your life out of convenience or necessity, but you do not like their company?	YES ☐	NO ☐	☐
C19. Do any friends, family or other people in your life ever take your money, borrow cigarettes, use your drugs, drink your alcohol, or get you to do things you really don't want to do?	YES ☐	NO ☐	☐
C20. Surveyor, do you detect signs of poor hygiene or daily living skills?	YES ☐	NO ☐	

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

D. WELLNESS

SCRIPT: OK, now I'm going to ask you some questions about your health…

QUESTION	**RESPONSE**		
D21. Where do you usually go for healthcare or when you're not feeling well?	☐ Hospital ☐ Clinic ☐ VA ☐ Other (Specify) ☐ Does not go for care		
Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?	**RESPONSE**		**REFUSED**
D22. Kidney disease/End Stage Renal Disease or Dialysis	YES ☐	NO ☐	☐
D23. History of frostbite, Hypothermia, or Immersion Foot	YES ☐	NO ☐	☐
D24. Liver disease, Cirrhosis, or End-Stage Liver Disease	YES ☐	NO ☐	☐
D25. HIV+/AIDS	YES ☐	NO ☐	☐
D26. History of Heat Stroke/Heat Exhaustion	YES ☐	NO ☐	☐
D27. Heart disease, Arrhythmia, or Irregular Heartbeat	YES ☐	NO ☐	☐
D28. Emphysema	YES ☐	NO ☐	☐
D29. Diabetes	YES ☐	NO ☐	☐
D30. Asthma	YES ☐	NO ☐	☐
Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?	**RESPONSE**		**REFUSED**
D31. Cancer	YES ☐	NO ☐	☐
D32. Hepatitis C	YES ☐	NO ☐	☐
D33. Tuberculosis	YES ☐	NO ☐	☐
OBSERVATION ONLY – DO NOT ASK: D34. Surveyor do you observe signs or symptoms of a serious health condition?	YES ☐	NO ☐	☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?	**RESPONSE**		**REFUSED**
D35. Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?	YES ☐	NO ☐	☐
D36. Have you consumed alcohol and/or drugs almost every day or every day for the past month?	YES ☐	NO ☐	☐
D37. Have you ever used IV drugs in the last 6 months?	YES ☐	NO ☐	☐
D38. Have you ever been treated for drug or alcohol problems and returned to drinking or using?	YES ☐	NO ☐	☐
D39. Have you used non-beverage alcohol (like cough syrup, rubbing alcohol, cooking wine, or anything like that) in the past month?	YES ☐	NO ☐	☐
D40. Have you blacked out because of your alcohol or drug use in the past month?	YES ☐	NO ☐	☐
OBSERVATION ONLY – DO NOT ASK: D41. Surveyor, do you observe signs or symptoms or problematic alcohol or drug abuse?	YES ☐	NO ☐	☐
D42. Ever been taken to a hospital against your will for a mental health reason?	YES ☐	NO ☐	☐
D43. Gone to the emergency room because you weren't feeling 100% well emotionally? Or because of your nerves?	YES ☐	NO ☐	☐
D44. Spoken with a psychiatrist, psychologist or other mental health professional in the last 6 months because of your mental health? (whether that was voluntary or because someone insisted that you do so?	YES ☐	NO ☐	☐
D45. Had a serious brain injury or head trauma?	YES ☐	NO ☐	☐
D46. Ever been told you have a learning disability or developmental disability?	YES ☐	NO ☐	☐
Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?	**RESPONSE**		**REFUSED**
D47. Do you have any problems concentrating or remembering things?	YES ☐	NO ☐	☐
OBSERVATION ONLY – DO NOT ASK: D48. Surveyor, do you detect signs or symptoms of severe, persistent mental illness or severely compromised cognitive functioning?	YES ☐	NO ☐	☐
D49. Have you had any medicines prescribed to you by a doctor that you do not take, sell, had stolen, misplaced, or where the prescriptions were never filled?	YES ☐	NO ☐	☐
D50. Have you experienced any emotional, physical, psychological, sexual or other type of abuse or trauma in your life which you have not sought help for, and/or which has caused your homelessness?	YES ☐	NO ☐	☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

SCRIPT: Finally I'd like to ask you some questions to help us better understand homelessness, and improve housing and support services.

What is your gender?	☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Decline to State
(If female:) Is there a chance that you might be pregnant?	☐ Yes ☐ No ☐ Refused
If yes, are you getting prenatal care?	☐ Yes ☐ No ☐ Refused
Do you have any children?	☐ Yes ☐ No ☐ Refused
If yes, what are their ages?	
If yes, where do they live?	☐ Family ☐ Friend ☐ Foster Care ☐ Other (specify)
Have you ever served in the US Military?	☐ Yes ☐ No ☐ Decline to State
If yes, which war/war era did you serve in?	☐ Korean War (June 1950-January 1955) ☐ Vietnam Era (August 1964-April 1975) ☐ Post Vietnam (May 1975-July 1991) ☐ Persian Gulf Era (August 1991-Present) ☐ Afghanistan (2001-Present) ☐ Iraq (2003-Present) ☐ Other (Specify) ☐ Refused
If yes, what was the character of your discharge?	☐ Honorable ☐ Other than honorable ☐ Bad Conduct ☐ Dishonorable ☐ Refused
What is your citizenship status?	☐ US Citizen ☐ Legal Resident ☐ Undocumented ☐ Refused
Where did you live prior to becoming homeless?	☐ Sonoma County ☐ Northern CA ☐ Other part of CA ☐ Elsewhere (Specify:)
Have you ever been in foster care?	☐ Yes ☐ No ☐ Refused
Have you ever been in jail?	☐ Yes ☐ No ☐ Refused
Have you ever been in prison?	☐ Yes ☐ No ☐ Refused
Do you have any pets?	☐ Yes ☐ No ☐ Refused
If yes, did your animal play a role in your becoming homeless?	☐ Yes ☐ No ☐ Refused
Do you have a permanent physical disability that limits your mobility? (i.e., wheelchair, amputation, unable to climb stairs)?	☐ Yes ☐ No ☐ Refused
What kind of health insurance do you have, if any? (check all that apply)	☐ Medi-Cal ☐ Medicare ☐ VA ☐ Private ☐ Other (specify):
On a regular day, where is it easiest to find you, and what time of day is easiest to do so?	

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

Is there a phone number and/or email where someone can get in touch with you or leave you a message?	
OK, now I'd like to take your picture. May I?	☐ Yes ☐ No ☐ Refused

Attachment 10c – VI-SPDAT Screening for Families

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)
Prescreen for Families with Children

Consent for Interview – *complete this form for each adult.*

We are here today to talk to you about your housing and service needs. All of the information we collect is completely confidential. Your location will not be shared with law enforcement. We are doing this study to find out about the health status of homeless people in Sonoma County, so we can design services to better help people.

If you give us permission, we will ask you some questions today for about 10 minutes and take a picture of you so we can identify you at a later date. These questions are about your health and housing and we will also ask for your social security number. By participating in the interview you give permission to the Sonoma County Continuum of Care to provide your information to authorized agencies for the purpose of furthering services and housing in this community.

Some of the questions we ask might make you feel uncomfortable or be upsetting. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break or to skip any of the questions. The information that you tell us during the interview will be stored in a secure database and also be shared with outreach workers and case managers who will follow up with you for services. All of your information will be kept secure and individuals who will see it have signed confidentiality waivers and will not share your information. You can skip any questions you do not want to answer, end the interview at any point, or choose to not have your picture taken. At anytime you can request that your information be removed from the database. We will give you a $5 food card at the end of the interview to thank you for your time. No one will be upset or angry if you decide not to be interviewed today.

SIGN BELOW IF AGREEING TO BE INTERVIEWED
Your signature (or mark) below indicates that you have read (or been read) the information provided above, have gotten answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

_____ _____
Date Signature (or Mark) of Participant

_____
Printed Name of Participant

Please sign here if you also agree to have your picture taken: _____
Signature (or Mark) of Participant

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

GENERAL INFORMATION/CONSENT (EtO Demographics – complete separately for HOH 1 and 2)

HEAD OF HOUSEHOLD 1	
First Name	Last Name
Nickname	Social Security number
How old are you? (Age)	What's your Date of Birth (DOB?)
What is your gender?	☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Decline to State
What is your Primary Race?	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused to answer
What is your Ethnicity?	☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ Doesn't Know ☐ Refused to answer
What is your citizenship status?	☐ US Citizen ☐ Legal Resident ☐ Undocumented ☐ Refused
Are you a Veteran?	☐ Yes ☐ No
(Demographics Disability Status) Do you have a permanent physical disability that limits your mobility? (i.e., wheelchair, amputation, unable to climb stairs)?	☐ Yes ☐ No ☐ Refused
In what language do you feel best able to express yourself?	_____
What approximate date did you first arrive in Sonoma County? (use Jan 1 of year if date unknown)	_____
What approximate date did you first become homeless? (use Jan 1 of year if date unknown)	_____
Do you have an email you use (enter if so)	
Do you have a primary phone you use (enter if so)	
Image Consent Demographic (See Question F.77)	☐ Yes ☐ No ☐ Refused
Note: The consent to participate in the VI-SPDAT survey is located at the top of the TouchPoint Assessment	

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

EtO Tab 1:

A. **GENERAL INFORMATION**

Date Taken _____ **Time Start/End** _____ **Taken By** _____
Location _____

CHILDREN				
A.21 Total number of children under the age of 18 that are currently with the head(s) of household		**RESPONSE**		**REFUSED** ☐
A.22 How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed?		**RESPONSE**		**REFUSED** ☐
Last Name	**First Name**	**How old?**		**Date of Birth**
Only ask the following question when there is at least one female head of household, and/or if there is at least one female child 13 years of age or older: **F.5** Is there a chance that any family member might be pregnant?		**YES** ☐	**NO** ☐	**REFUSED** ☐
F.6 *If yes, is that family member getting prenatal care?*		**YES** ☐		**NO** ☐
F.7 Does your family have any pets?		**YES** ☐		**NO** ☐
F.8 *Did your animal play a role in your family becoming homeless?*		**YES** ☐		**NO** ☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

EtO Tab 2:

B. HISTORY OF HOUSING & HOMELESSNESS

QUESTION	RESPONSE	REFUSED
F.9 What is the total length of time you and your family have lived on the streets or in shelters (*INDICATE IN NUMBER OF MONTHS*)?		☐
F.10 In the past 3 years, how many times have you and your family been housed, and then homeless again?		☐

C. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when 6 months ago was, just let me know.

QUESTION	RESPONSE		REFUSED
F.11 In the past 6 months, how many times have you and/or members of your family been to the emergency room?			☐
F.12 In the past 6 months, how many times have you and/or members of your family had an interaction with the police?			☐
F.13 In the past 6 months, how many times have you been taken to the hospital in an ambulance?			☐
F.14 In the past six months how many times have you and/or members of your family used a crisis service, including suicide prevention or another crisis hotline?			☐
F.15 In the past 6 months, how many times have you and/or members of your family been hospitalized as an inpatient? Including in a mental health hospital?			☐
F.16 Since becoming homeless, have you or any family member been attacked or beaten up?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.17 Have you or any family member threatened, or tried to harm themselves or anyone else in the last year?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.18 Do you or any member of the family have any legal stuff going on right now that may result in you being locked up or having to pay fines?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.19 Does anybody force or trick you or any member of the family to do things that you do not want to do?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.20 Do you or any member of the family ever do things that may be considered to be risky? Like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, anything like that?	**YES** ☐	**NO** ☐	**REFUSED** ☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

QUESTION	RESPONSE	REFUSED
F.21 I'm going to read types of places people sleep. Please tell me which one that you and your family sleep at most often. (Check only one.)	☐ Shelter ☐ Street, sidewalk or doorway ☐ Car, Van, or RV ☐ Park, beach, camping Other (SPECIFY): _____	

EtO Tab 3:

D. SOCIALIZATION & DAILY FUNCTIONS

QUESTION	RESPONSE		REFUSED
F.23 Is there anybody that thinks you or any family member owes them money?	**YES** ☐	**NO** ☐	☐
F.24 Does the family have any money coming in on a regular basis? through a job, government benefits, or even working under the table, recycling, sex work, odd jobs, day labor, or anything like that?	**YES** ☐	**NO** ☐	☐
F.25 Does your family have enough money to meet all expenses on a monthly basis?	**YES** ☐	**NO** ☐	☐
F. 26 Do you and each member of the family have planned activities each day other than just surviving that bring you happiness and fulfillment?	**YES** ☐	**NO** ☐	☐
F.27 Do you have any friends, family or other people in your life out of convenience or necessity, but you do not like their company?	**YES** ☐	**NO** ☐	☐
F.28 Do any friends, family or other people in you or your family's life ever take your money, borrow cigarettes, use your drugs, drink your alcohol, or get you to do things you really don't want to do?	**YES** ☐	**NO** ☐	☐
F. 29 Surveyor, do you detect signs of poor hygiene or daily living skills of any family member?	**YES** ☐	**NO** ☐	

EtO Tab 4:

E. WELLNESS

SCRIPT: OK, now I'm going to ask you some questions about your health…

QUESTION	RESPONSE
F.30 Where do you and other family members usually go for healthcare or when you're not feeling well?	☐ Hospital ☐ Clinic ☐ VA ☐ Other (Specify) ☐ Does not go for care

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

Do you or any family member have now, ever had, or had a healthcare provider ever told you that you have any of the following medical conditions?	**RESPONSE**		**REFUSED**
F.31 Kidney disease/End Stage Renal Disease or Dialysis	**YES** ☐	**NO** ☐	☐
F.32 History of frostbite, Hypothermia, or Immersion Foot	**YES** ☐	**NO** ☐	☐
F.33 Liver disease, Cirrhosis, or End-Stage Liver Disease	**YES** ☐	**NO** ☐	☐
F.34 HIV+/AIDS	**YES** ☐	**NO** ☐	☐
F.35 History of Heat Stroke/Heat Exhaustion	**YES** ☐	**NO** ☐	☐
F.36 Heart disease, Arrhythmia, or Irregular Heartbeat	**YES** ☐	**NO** ☐	☐
F.37 Emphysema	**YES** ☐	**NO** ☐	☐
F.38 Diabetes	**YES** ☐	**NO** ☐	☐
F.39 Asthma	**YES** ☐	**NO** ☐	☐
F.40 Cancer	**YES** ☐	**NO** ☐	☐
F.41 Hepatitis C	**YES** ☐	**NO** ☐	☐
F.42 Tuberculosis	**YES** ☐	**NO** ☐	☐
F.43 OBSERVATION ONLY – DO NOT ASK: Surveyor do you observe signs or symptoms of a serious health condition?	**YES** ☐	**NO** ☐	☐
F.44 Have you or any member of the family ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do?	**YES** ☐	**NO** ☐	☐
F.45 Have you or any member of the family consumed alcohol and/or drugs almost every day or every day for the past month?	**YES** ☐	**NO** ☐	☐
F.46 Have you or any member of the family ever used IV drugs in the last 6 months?	**YES** ☐	**NO** ☐	☐
F.47 Have you or any member of the family ever been treated for drug or alcohol problems and returned to drinking or using drugs?	**YES** ☐	**NO** ☐	☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

F.48 Have you or any member of the family used non-beverage alcohol (like cough syrup, rubbing alcohol, cooking wine, or anything like that) in the past month?	**YES** ☐	**NO** ☐	☐
Do you or any family member have now, ever had, or had a healthcare provider ever told you that you have any of the following medical conditions?	**RESPONSE**		**REFUSED**
F.49 Have you or any family member blacked out because of alcohol or drug use in the past month?	**YES** ☐	**NO** ☐	☐
F.50 Has any family member under the legal drinking age consumed alcohol four or more times in the last month or used drugs at any point in time during the last month—including marijuana or prescription pills to get high?	**YES** ☐	**NO** ☐	☐
F.51 OBSERVATION ONLY – DO NOT ASK: **Surveyor**, do you observe signs or symptoms or problematic alcohol or drug abuse?	**YES** ☐	**NO** ☐	☐
F.52 Have you or any family member ever been taken to a hospital against your will for a mental health reason?	**YES** ☐	**NO** ☐	☐
F.53 Have you or any family member gone to the emergency room because they weren't feeling 100% well emotionally? Or because of their nerves?	**YES** ☐	**NO** ☐	☐
F.54 Have you or any family member spoken with a psychiatrist, psychologist or other mental health professional in the last 6 months because of your mental health? (whether that was voluntary or because someone insisted that you do so?)	**YES** ☐	**NO** ☐	☐
F.55 Have you or any family member had a serious brain injury or head trauma?	**YES** ☐	**NO** ☐	☐
F.56 Have you or any family member ever been told they have a learning disability or developmental disability?	**YES** ☐	**NO** ☐	☐
F.57 Do you or any member of your family have any problems concentrating or remembering things?	**YES** ☐	**NO** ☐	☐
F.58 OBSERVATION ONLY – DO NOT ASK: **Surveyor**, do you detect signs or symptoms of severe, persistent mental illness or severely compromised cognitive functioning?	**YES** ☐	**NO** ☐	☐
ASK THIS QUESTION ONLY IF THERE IS AT LEAST 1 "YES" RESPONSE IN EACH OF THE FOLLOWING: D22-D33; D34-D42; AND D43-D49:			
F.59 You indicated in your responses that there is a medical condition, experience with mental health services and experience with substance use. Is that the SAME member of the family in all of those instances?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.60 Have you had any medicines prescribed to you by a doctor that you do not take, sell, had stolen, misplaced, or where the prescriptions were never filled?	**YES** ☐	**NO** ☐	☐
F.61 Yes or No—Have you or any member of your family experienced any emotional, physical, psychological, sexual or other type of abuse or trauma which help was not sought for, and/or which has caused your homelessness?	**YES** ☐	**NO** ☐	**REFUSED** ☐

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

EtO Tab 5:

F. FAMILY UNIT

F.62 Do any of your children spend two or more hours per day when you don't know where they are?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.63 On most days, do any children do tasks that adults would normally do like preparing meals, getting other children ready for bedtime, shopping, cleaning the apartment, or anything like that?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.64 What is the total number of times adults in the family have changed in the family over the past year because of things like new relationships or a breakdown in the relationship, prison, military deployment, or anything like that?	_____		
F.65 What is the total number of times that children have been separated from the family or returned to the family over the past year?			
F.66 Are there any school-aged children that are not enrolled in school or missing more days of school than they are attending?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.67 Right now or at any point in the last 6 months have any of your children been separated from you to live with a family member or friend?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.68 Has there been any involvement with any member of your family and child protective services in the last 6 months—even if it was resolved?	**YES** ☐	**NO** ☐	**REFUSED** ☐
F.69 Have you had anything in family court over the past 6 months or anything currently being considered in family court?	**YES** ☐	**NO** ☐	**REFUSED** ☐

SCRIPT TEXT: Finally I'd like to ask you some questions to help us better understand homelessness, and improve housing and support services.

EtO Tab 6:

Miscellaneous Community Questions

F.70 If you served in the US Military, which war/war era did you serve in?	☐ Korean War (June 1950-January 1955) ☐ Vietnam Era (August 1964-April 1975) ☐ Post Vietnam (May 1975-July 1991) ☐ Persian Gulf Era (August 1991-Present) ☐ Afghanistan (2001-Present) ☐ Iraq (2003-Present) ☐ Other (Specify) ☐ Refused
F.71 If yes, what was the nature of your discharge?	☐ Honorable ☐ Other than honorable ☐ Bad Conduct ☐ Dishonorable ☐ Refused
F.72 Have you ever been in foster care?	☐ Yes ☐ No ☐ Refused

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Families with Children

F.73 Have you ever been in jail?	☐ Yes ☐ No ☐ Refused
F.74 Have you ever been in prison?	☐ Yes ☐ No ☐ Refused
F.75 What kind of health insurance do you have, if any? (check all that apply)	☐ Medi-Cal ☐ Medicare ☐ VA ☐ Employer Provided ☐ COBRA ☐ Private Pay ☐ Other (specify): _____
F.76 On a regular day, where is it easiest to find you, and what time of day is easiest to do so?	Location: Time:
F.77 OK, now I'd like to take your picture. May I? EtO *(Image Consent Demographic and Image container fields)* ☐ Yes ☐ No	

ATTACHMENT 11 – Sources Used in Local Research

National Alliance to End Homelessness Coordinated Assessment Planning Toolkit

http://www.endhomelessness.org/library/entry/coordinated-assessment-toolkit-planning-and-assessment

Coordinated Assessment – *The Advanced Class*

Matt White, Abt Associates

Coordinated Assessment Models and Principals under the CoC – One CPD

https://www.hudexchange.info/resource/3145/coordinated-assessment-models-and-principles-under-the-coc-program-interim-rule/

U.S. Department of Housing and Urban Development – CPD-14-012 (July 28, 2014)

http://portal.hud.gov/hudportal/documents/huddoc?id=14-12cpdn.pdf

U.S. Interagency Council on Homelessness, "Retooling the Homeless Crisis Response System," webinar

http://usich.gov/media_center/videos_and_webinars/retooling_the_homeless_crisis_response_system

100,000 Homes Campaign – SPDAT and VI-SPDAT Evidence Brief

http://100khomes.org/resources/spdat-and-vi-spdat-evidence-brief

OrgCode Consulting – Makers of SPDAT Tools

http://www.orgcode.com/product/vi-spdat/

Building Changes – End Homelessness Together (A Road Map for Coordinated Entry)

Combined study by King, Pierce and Snohomish Counties in Washington State
http://www.buildingchanges.org/news/item/357-an-ambitious-plan-to-end-homelessness-in-washington-state

ATTACHMENT 12 – Coordinated Intake Workgroup Members

As our system has been developed thus far and continues to do so, the Continuum of Care would like to thank the following individuals and organizations for their input and professional expertise:

Buckelew Programs	Kristi	Toprakci
	Lisa	Planting
Catholic Charities	Amy	Ramirez
	Brandon	Thibeauld
	Doreen	Best
	Jennielynn	Holmes
Cloverdale Community Outreach	Colleen	Halbohm
Committee on the Shelterless	Jed	Heibel
	Jules	Pelican
	Mike	Johnson
	Monica	Savon
	Robin	Phoenix
	Tamara	Maimon
	William	Hess
Community Action Partnership	Pamela	Powers
Community and Family Services Agency	Mary Kaye	Gerski
	Stephanie	Hopkins
Community Development Commission	Cindy	Rich
	Jenny	Abramson
	Teddie	Pierce
Community Support Network	Gayle	Thomas
	Marissa	Johnston
	Sheri	Bright
	Tom	Bieri
Community Turning Point (Formerly DAAC)	Lynn	Companario
	Susan	Hertel
County of Sonoma	Gerard	LaLonde-Berg
	Jenny	Mercado
Face to Face	Mary	Maloney
Interfaith Shelter Network	Beth	Hennigan
	Carmen	Bonin
	Rob	Durborough
	Sienna	Johnston
Legal Aid Sonoma County	Ronit	Rubinoff
Mobile Support Services	Melissa	Jones
North Bay Veterans Resource Center	Billy	Patrick
	Cory	Lemings
	Emily	Smith
	Mary	Haynes
Petaluma People Services	Elece	Hempel

Social Advocates for Youth	Anita	Rosales
	Heather	Sweet
Sonoma County 211	Bonafacio	Torres
	Ellen	LaBruce
	Jim	Bray
	Toni	Fitzpatrick
Sonoma County Behavioral Health	Cruz	Cavallo
Sonoma Overnight Support	Jeffrey	Severson
	Susana	Romo
Veteran's Administration	Kimberly	Valadez
VOICES Sonoma	Amber	Twitchell
YWCA	Alicia	Sims
	Dawn	Silveira